**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04501

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ollie Mae Perry

2. Date of Death: Month January Day 31 Year 2001

3. Time of Death: 4:45 P.M.

4a. Facility Name (If not institution, give street and number): Millennium at South River

4b. City, Town, or Location of Death: Edgewater

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 415-60-1436

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 29, 1922

9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Harwood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 146 Polling House Road

10f. Zip Code: 20776

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Worker

16b. Kind of Business/Industry: School System

17. Father's Name (First, Middle, Last): Charlie Jenkins

18. Mother's Name (First, Middle, Maiden Surname): Sarah Catherine Sneed

19a. Informant's Name/Relationship (Type, Print): Joann P. Vignola/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 146 Polling House Road Harwood, MD 20776

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Short Creek Cemetery

Date: 2-1-01

20c. Location - City or Town, State: Athens, Tennessee

21. Signature of Funeral Service Licensee: Robert J. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Cardiac Arrhythmia. — Approx. 10 mts.

Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular disease — more than 1 year.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Mitral Valve disease.

Leg Ulcer.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gyan C Surana

29c. License number: D 50653

29d. Date signed (Month, Day, Year): 2/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GYAN C SURANA 5851- Deale Churchton Road. Deale. MD. 20751

**State Registrar**

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04502

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: SADIE PACK

2. Date of Death (Month, Day, Year): FEB. 1 2001

3. Time of Death: 5:30 am

4a. Facility Name *(If not institution, give street and number)*: 848 B&A BLVD.

4b. City, Town, or Location of Death: SEVERNA PARK

4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 212-18-5355

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 27 1917

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: SEVERNA PARK

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 848 B&A BLVD.

10f. Zip Code: 21146

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 10th

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: WAITRESS

16b. Kind of Business/Industry: MANRESA

17. Father's Name *(First, Middle, Last)*: CLARENCE DAY

18. Mother's Name *(First, Middle, Maiden Surname)*: ANNIE GREEN

19a. Informant's Name/Relationship *(Type, Print)*: LORRAINE GOUGH (NEICE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 260 B. HILL TOP LA. APT.208 ANNAPOLIS, MD. 21403

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CARPENTER HILL CEME.

Date: 2/6/01

20c. Location - City or Town, State: ROUND BAY, MD.

21. Signature of Funeral Service Licensee: Larry D. Reese M00483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of the lungs — months

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. with Metastasis

Due to (or as a consequance of):

c.

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: Sickle Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cesa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residance 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D02583

29d. Date signed *(Month, Day, Year)*: 2/02/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANASTACIO SUBONG, JR. MD 206 CRAIN HWY. Glen Burnie, Md 21061

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: P Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

AMEND#10E AACO HEALTH 2/5/01 cmh

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04503

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Francis John Panzer, Jr.

2. Date of Death: Month January Day 25th Year 2001

3. Time of Death: 2:05A

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 215-26-4706

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 9, 1931

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 736 Dill Road ~~126 Magothy Bridge Road~~

10f. Zip Code: 21146

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired Banker

16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): Francis J. Panzer, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Bessie W. Pasquith

19a. Informant's Name/Relationship (Type, Print): Amy Jo Panzer/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 383 Eagle Hill Road, Pasadena, MD 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: Jan 27 2001

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas SALK

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was cesa referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D48006

29d. Date signed (Month, Day, Year): January 25th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFI BONITEY, 301 Hospital Dr, Glen Burnie, MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

PANZER, FRANCIS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04504

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Omro Willmore Powley
2. Date of Death (Month, Day, Year): January 31 2001
3. Time of Death: 7:10 pm
4a. Facility Name (If not institution, give street and number): Dorchester General Hospital
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

**Funeral Director**

5. Social Security Number: 214-18-4095
6. Sex: 1☒ M 2☐ F
7. Age (in yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 3 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Crapo
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2736 Wesley Church Road
10f. Zip Code: 21626
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highast grade completed): Elemantary/Secondery (0-12): 6; College (1-4or 5+):
16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired): workman
16b. Kind of Business/Industry: seafood industry

17. Fether's Neme (First, Middle, Last): Risdon Powley
18. Mother's Name (First, Middle, Maiden Surneme): Bertha Pritchett

19a. Informent's Neme/Reletionship (Type, Print): Nettie Powley - wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2736 Wesley Church Rd., Crapo, MD 21626

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Dorchester Memorial Park
Dete: 2-3
20c. Location - City or Town, Stete: Cambridge, Maryland

21. Signature of Funerel Service Licensee: [signature]
22. Name end Address of Facility: Thomas Funeral Home, PA
700 Locust St., Cambridge, MD 21613

**Physician /Medical Examiner**

23a. Part1. Enter the diseesa, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart feilure. List only ona cause on eech lina.

Approximete Interval Between Onset end Deeth

Immediete Ceusa (Final diseese or condition resulting in daeth): a. Small Cell Lung Cancer — 6 mos
Dua to (or es a consequence of):
Sequentially list conditions, if eny, leading to immediete ceusa. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest:
b. Due to (or es e consequance of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings eveileble prior to compiation of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☑ No
26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyeician:** To the best of my knowledge, daath occurred et the time, date and place, end due to tha causa(s) and mennar es steted. 2☐ **Medical Examiner:** On the besis of exemination end/or investigetion, in my opinion, daath occurred et the time, dete end place, and due to the ceuse(s) and menner steted.

29b. Signeture end titie of certifier: [signature] MD
29c. License number: D35622
29d. Date signed (Month, Dey, Year): 02-01-01

30. Neme end eddress of person who completed cause of deeth (item 23a) (Type, Print): CRAIG W CALDWELL 2 AURORA ST, CAMBRIDGE, MD

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 02 2001
32. Registrer's Signeture: Penny D. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04505

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Luis S. Quinnones
2. Date of Death (Month, Day, Year): January 24, 2001
3. Time of Death: 11:50 PM
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 577-05-2387
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 19, 1910
9. Birthplace (State or Foreign Country): Philippines

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 11713 Emack Road
10f. Zip Code: 20705
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Unknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Ricen, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Banquet Waiter
16b. Kind of Business/Industry: Hotel

17. Father's Nama (First, Middle, Last): Unknown Quinnones
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19e. Informant's Name/Relationship (Type, Print): Deanna L. Shutt (granddaughter)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 11713 Emack Road Beltsville, Maryland 20705

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): George Washington Cemetery
Dete: Jan. 29 2001
20c. Location - City or Town, Stata: Adelphi, Maryland

21. Signature of Funeral Service Licensee: James E Dailey
22. Nama and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onsat and Death)

Immediate Cause (Final diseese or condition resulting in death): a. Cerebrovascular Accident

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Multilobar Pneumonia

23b. Did tobacco uas contributs to the causes of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 ☒ No

25. Was cese referred to medicel examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only ona): Hospitel: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner steted.

29b. Signatura and title of certifier: William A Warren MD
29c. License number: D13916
29d. Date signed (Month, Day, Year): January 25, 2001

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): William A. Warren, MD 321 Prince George Street, Laurel, MD

**State Registrar**

31. Date filed (Month, Dey, Year): JAN 30 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04506

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Dr. Herbert Rothfeld
2. Data of Death (Month, Day, Year): January 31, 2001
3. Tima of Death: 6:30 PM
4a. Facility Name *(If not institution, giva street and number)*: 5325 Strathmore Ave.
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 579-46-4791
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 66 Yrs. — If Undar 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: May 1, 1934
9. Birthplace *(State or Foraign Country)*: New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street end Number: 5325 Strathmore Ave.
10f. Zip Code: 20895
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yes, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Podiatrist
16b. Kind of Business/Industry: Medical

17. Fathar's Nama *(First, Middle, Last)*: Herman Rothfeld
18. Mother's Name *(First, Middle, Maidan Surnama)*: Fannie Miller

19a. Informant's Name/Relationship *(Type, Print)*: Frances Rothfeld/ Wife
19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 5325 Strathmore Ave., Kensington, MD 20895

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Piece of Disposition *(Nama of cematary, crematory or othar place)*: King David Mem. Gdns.
Data: Feb. 2, 2001
20c. Location - City or Town, Stata: Falls Church, VA

21. Signatura of Funaral Sarvice Licensee ▶
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

**Physician /Medical Examiner**

23a. Part1. Entar tha diseesa, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on aach line. — Approximata Intarval Between Onset end Daath

Immediate Ceusa (Final diseesa or condition rasulting in death)
a. Dysphagia, aspiration pneumonia
Due to (or as a consequence of):
b. Shy Drager Autonomic Neuropathy
Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
Dua to (or as e consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wera autopsy findings available prior to complation of causa of death? 1☐ Yas 2☐ No

25. Wes casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☒ Residence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how Injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha causa(s) and mannar stated.

29b. Signatura and title of certifier ▶ Norton Elson
29c. Licanse number: D20362
29d. Data signed *(Month, Day, Year)*: February 1, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Norton Elson, M.D. 6525 Belcrest Rd, Suite 208, Hyattsville, MD 20781

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signatura ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-0389-031
jm
ANTHONY
RICCI

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

AMENDED# 23, ,27,28 per ME G793 032001 SS

Reg. No. 2001 04507

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Anthony John Ricci

2. Date of Death — Month: JANUARY Day: 23, Year: 2001

3. Time of Death: 23:18 PM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 215-68-8077

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 44 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 9, 1956

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 804 Brice Road

10f. Zip Code: 20852

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Master Technician

16b. Kind of Business/Industry: Auto Industry

17. Father's Name (First, Middle, Last): Luigi Ricci

18. Mother's Name (First, Middle, Maiden Surname): Mary Katherine (not available)

19a. Informant's Name/Relationship (Type, Print): Elizabeth C. Ricci/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 804 Brice Road, Rockville, Maryland 20852

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: Jan. 26 2001

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ralph Fourt M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA DUE TO MIXED DRUG INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year) found: 1-23-01

28b. Time of Injury: unknown M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found: residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 804 Brice Rd. Rockville, Montgomery County, MD

29a. Certifier (Check only one) 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Myles L Noetz, M.D.

29c. License number: OCME

29d. Date signed (Month, Day, Year): JANUARY 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04508

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ann Theresa Reen

2. Date of Death (Month, Day, Year): January 24, 2001

3. Time of Death: 7:41 pm

4a. Facility Name (If not institution, give street and number): Northampton Manor Nursing Center

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 067-01-6899

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 25, 1914

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Adamstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2301 Mt. Ephraim Road

10f. Zip Code: 21710

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Dept. of Education

17. Father's Name (First, Middle, Last): Thomas Patrick Shalvey

18. Mother's Name (First, Middle, Maiden Surname): Ellen T. Murphy

19a. Informant's Name/Relationship (Type, Print): Denyse Slovick (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4682 Bonneville Lane, Woodbridge, Virginia 22193

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem. | Date: 1/31/01

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Tawana M. Flint

22. Name and Address of Facility: Murphy Falls Church Funeral Home, 1102 W. Broad St., Falls Church, Va. 22046

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. **Atherosclerotic Heart Disease** — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

**Right Hip Fracture**

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28c. Data of Injury (Month, Day, Year): Dec 05, 2001 3:00p M

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Fell while walking

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): At Home - Assisted Living

28f. Location (Street and Number or Rural Route Number, City or Town, State): 990 Waterford Dr (Sunrise) Frederick, Maryland

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Zarick, Jr. M.D.

29c. License number: D35164

29d. Date signed (Month, Day, Year): January 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703

**State Registrar**

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

-01-0410-031
CJ
Sue Stottmeister

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04509

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): SUE WEN STOTTMEISTER
2. Date of Death: Month: January; Day: 24; Year: 2001
3. Time of Death: 08:55 P.M.
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 012-42-7311
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 48 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 27, 1952
9. Birthplace (State or Foreign Country): MASSACHUSETTS

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13726 DRAKE DRIVE
10f. Zip Code: 20853
10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER AIDE
16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): GEORGE T. G. LEE
18. Mother's Name (First, Middle, Maiden Surname): MEE H. YEE

19a. Informant's Name/Relationship (Type, Print): HENRY P. STOTTMEISTER (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13726 DRAKE DRIVE; ROCKVILLE, MARYLAND 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKLAWN MEMORIAL PARK
Date: JAN. 28, 2001
20c. Location - City or Town, State: ROCKVILLE, MARYLAND

21. Signature of Funeral Service Licensee: James J. Schwartz
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904-2891

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Multiple Blunt Force Injuries and Strangulation
~~Due to (or as a consequence of):~~
b. with Cold Exposure From Sexual
~~Due to (or as a consequence of):~~
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Assault
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 1/24/01 (Found)
28b. Time of Injury: 7:18 PM (Found)
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject Beaten, Strangled and Exposed Naked to Cold
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Park
28f. Location (Street and Number or Rural Route Number, City or Town, State): Aspen Hill Regional Park Montgomery County, Maryland

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Joseph Pestaner, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 25, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04510

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOSEPH STEINBERG

2. Date of Death (Month, Day, Year): FEBRUARY 1, 2001

3. Time of Death: 8:55 AM

4a Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 577-16-2334

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 8, 1915

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11419 COMMONWEALTH DRIVE #102

10f. Zip Code: 20852

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 2.5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): REALTOR/BROKER

16b. Kind of Business/Industry: REAL ESTATE

17. Father's Name (First, Middle, Last): DAVID STEINBERG

18. Mother's Neme (First, Middle, Maiden Surname): BERTHA GROSSMAN

19a. Informant's Name/Reletionship (Type, Print): SOPHIE J. STEINBERG/WIFE

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 11419 COMMONWEALTH DRIVE #102, ROCKVILLE, MD 20852

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): UNITED HEBREW CEMETERY

Date: FEB 2, 2001

20c. Location - City or Town, Stete: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee:

22. Name end Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. RESPIRATORY FAILURE

Due to (or as a consequence of): SEPTICEMIA

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ALCOHOLIC LIVER DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier:

29c. License number: D 56219

29d. Date signed (Month, Day, Year): 2/1/01

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print): DR. KATARZY OSTRZENSKA 2309 SHOREFIELD RD, SILVER SPRING, MARYLAND 20902

**State Registrar**

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Lenore G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04511

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HENRY STEIN
2. Date of Death Month / Dey / Year: JANUARY 30, 2001
3. Time of Death: 8:40 AM
4a. Facility Name (If not institution, give street end number): 3309 SIR THOMAS DRIVE #22
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 578-22-5583
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): JAN 21, 1921
9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3309 SIR THOMAS DRIVE #22
10f. Zip Code: 20904
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ACTION OFFICER
16b. Kind of Business/Industry: FEDERAL GOVERNMENT/ CIVIL ENGINEERING

17. Father'a Name (First, Middle, Last): JACOB STEIN
18. Mother's Name (First, Middle, Maiden Surneme): SHEVA "UNAVAILABLE"

19a. Informant's Name/Relationship (Type, Print): RUTH A. STEIN/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3309 SIR THOMAS DRIVE #22, SILVER SPRING, MD 20904

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): JUDEAN MEMORIAL GARDENS | Dete: FEB 01, 2001
20c. Location - City or Town, State: OLNEY, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20902

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute Myocardial Infarction — 6 min
Due to (or as a consequence of):
b. Atherosclerotic Hypertensive Cardiovascular Disease
Sequentielly fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part ft. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Hyperlipidemia

23b. Did tobacco uas contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24e. Wes en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residenca 6 [ ] Other (Specify)
27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Placa of Injury - At home, farm, atreet, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: [signature] Md.
29c. License number: D0000232
29d. Date signed (Month, Dey, Year): 1/30/01
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Morton Altschuler M.D. 1299-C Amberton Dr Silver Spring, Md 20902

**State Registrar**

31. Dete filed (Month, Dey, Year): FEB 02 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

6

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

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6

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04512

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| MEE | LUN | SOHO | JANUARY 22, 2001 | 10:32 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| LAUREL REGIONAL HOSPITAL | LAUREL | PRINCE GEORGE'S |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-54-0681 | 1☐ M 2☒ F | 73 Yrs. | | | JULY 1, 1927 | CHINA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | PRINCE GEORGE'S | MITCHELLVILLE | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10302 BALD HILL ROAD | 20721 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: ASIAN |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6th | | SEAMSTRESS | CLOTHING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| FOOK POY CHIN | YUN C. MOY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOHN M. SOHO (SON) | 10302 BALD HILL ROAD; MITCHELLVILLE, MARYLAND 20721 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | FORT LINCOLN CEMETERY | JAN. 27, 2001 | BRENTWOOD, MARYLAND |

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904-2891

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | 3 DAYS |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

THROMBOCYTOPENIA, PURPURA, CHOLESTATIC JAUNDICE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes ☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| ☒ Yes 2☐ No | ☒ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes ☒ No | Hospital: ☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| ☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D25430 | 01/23/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOHN MARGOLIS 13952 Baltimore Ave. Laurel, MD 20707

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JAN 29 2001 | ▶ [signature] |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04513

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: DAVID S. SMITH

2. Date of Death Month Dey Yeer: 01/ 25/2001

3. Time of Death: 3:15 P.M

4a. Facility Name *(If not institution, give street and number)*: 6705 KEYSTONE MANOR DR.

4b. City, Town, or Location of Death: FORESTVILLE

4c. County of Death: P.G.

**Funeral Director**

5. Social Security Number: 579-92-5675

6. Sex: 1 [X] M 2 [ ] F

7. Aga *(In yrs. last birthday)*: 38 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: 09/17/1962

9. Birthplace *(State or Foreign Country)*: WASHINGTON

Usual Residence of Decedent

10a. State: MD

10b. County: P.G.

10c. City, Town or Location: FORESTVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6705 KEYSTONE MANOR DR.

10f. Zip Code: 20747

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [X] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: DISABLED

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: ERNEST G. SMITH

18. Mother's Name *(First, Middle, Maiden Surname)*: DIANE L. HORNE

19e. Informant's Neme/Relationship *(Type, Print)*: DIANE L. SMITH (MOTHER)

19b. Meiling Addrass *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 2649 PARK PL. WASH. D.C. 20020

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: LINCOLN MEMORIAL

Data: 01/31/01

20c. Locatioo - City or Town, Stata: SUITLAND MARYLAND

21. Signature of Funaral Sarvice Licensee: Terry L. Austin

22. Nama and Address of Fecility: AUSTIN ROYSTER FUNERAL HOME 3821 14th ST. WASH. D.C. 20011

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in death): a. ACQUIRED IMMUNE DEFICIENCY SYNDROME — 10 years

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:

b.

Due to (or as e consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.: CHRONIC ACTIVE HEPATITIS; BONE MARROW SUPPRESSURE; ANEMIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Chack only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner es steted. 2 [ ] **Medicel Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: Lewis Marshall MD

29c. License number: MD. Z5618

29d. Date signed *(Month, Dey, Year)*: 1/29/01

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print): LEWIS W. MARSHALL MD 1160 Varnum Street, N.W. Washington, DC. 20017

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 02 2001

32. Registrer's Signeture: Irene G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend #18, 2/8/2001, GF, Montg. Co.

# Certificate of Death

Reg. No. 2001 04514

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dharam Singh

2. Date of Death: Month: January Day: 29, Year: 2001

3. Time of Death: 12:55PM

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 214-96-5678

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): April 12, 1961

9. Birthplace (State or Foraign Country): Trinidad

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Adelphi

10d. Insida City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9270 Adelphi Road Apt. 101

10f. Zip Coda: 20783

10g. Citizen of What Country?: Trinidad

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: East Indian

15. Decedent's Education (Specify only highest grada complatad)

Elamantary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Security Guard

16b. Kind of Businass/Industry: Security

17. Father's Name (First, Middla, Last): Lal Beharry Singh

18. Mother's Nema (First, Middla, Maiden Sumama): Pearly ~~Maharaji~~ Maharaj

19a. Informant's Neme/Ralationship (Type, Print): Lal B. Singh/Father

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 9270 Adelphi Rd. Apt. 101 Adelphi, MD 20783

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Nema of cematary, crametory or othar placa): Ft. Lincoln Crematory

Data: 02/05/01

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Andrew Justheim

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904

**Physician /Medical Examiner**

23a. Part1. Enter tha diseasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona cause on eech line.

| | | Approximate Intarval Batween Onsat and Death |
|---|---|---|
| Immadiata Ceusa (Final disaasa or condition rasulting in deeth) a. | Septecemia | 10 Days |
| Dua to (or as a consequence of): b. | Renal Failure | Several years |
| Sequentially list conditions, if any, leeding to immadiata cause. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last — Due to (or as a consequanca of): c. | Hypertension | Several years |
| Dua to (or as a consequanca of): d. | Diabetes mellitus | Several years |

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings available prior to complation of causa of daath? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Placa of Daath (Chack only one): Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Rasidance 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be datarmined

28a. Deta of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stata)

29a. Cartifiar (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledga, death occurred at tha time, date end place, and due to tha causa(s) end mennar es stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigetion, in my opinion, daath occurred at the lime, date and piece, end due to tha cause(s) end mennar stated.

29b. Signatura and title of certifier: M Karim MD

29c. Licensa number: D18895

29d. Data signad (Month, Day, Year): January 30, 2001

30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print): MOBARAK KARIM, 7610 CARROLL AVE, TAKOMA PARK, MD 20912

**State Registrar**

31. Deta filed (Month, Dey, Year): FEB 02 2001

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04515

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edgar Silverman
2. Date of Death (Month, Day, Year): Jan. 29, 2001
3. Time of Death: 1:50A.

4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 198-10-3929
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar.3,1915
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 7420 Westlake Terrace, #410
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Social Worker
16b. Kind of Business/Industry: District of Columbia Juvenile Court

17. Father's Name (First, Middle, Last): Wolf Silverman
18. Mother's Name (First, Middle, Maiden Surname): Esther Cravitz Briskin

19a. Informant's Name/Relationship (Type, Print): William Silverman - son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 West Kirke St. Chevy Chase, Maryland 20815

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Data: 1/30/2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Respiratory Failure | 72 Hr |
| Due to (or as a consequence of): b. | Pneumonia | 72 Hr |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Chronic Obstructive Pulmonary Disease | 2+ years |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Vascular Disease
Hypertension
Recent Sigmoid Volvulus

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D32610
29d. Date signed (Month, Day, Year): 1-29-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T.J. McNamara 10215 Fernwood Rd, Bethesda, Maryland 20817

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

SILVERMAN, EDGAR 01/29/01 0150

GF

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**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04516

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Florence Leah Shroder
2. Date of Death Month Day Year: January 27, 2001
3. Time of Death: 9:20 AM
4a. Facility Name *(If not institution, give street and number)*: 1316 Fenwick Lane, Apt.607
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-32-2228
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 16, 1919
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1316 Fenwick Lane, Apt. 607
10f. Zip Code: 20910
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Librarian
16b. Kind of Business/Industry: Public Library

17. Father's Name *(First, Middle, Last)*: Nathan Davis
18. Mother's Name *(First, Middle, Maiden Surname)*: Ida Cohn

19a. Informant's Name/Relationship *(Type, Print)*: Susan J.S. Lasser/ daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 106 Cosgrove Ln., Taylors, SC 29687

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Elmlawn Cemetery | Date: Jan. 29, 2001
20c. Location - City or Town, State: Tonawanda, NY

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. End Stage Heart Failure
Due to (or as a consequence of):
b. Diastolic Dysfunction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Pulmonary Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Susan Leggett-Johnson MD
29c. License number: D38149
29d. Date signed *(Month, Day, Year)*: Jan. 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Susan Leggett-Johnson, MD 6525 Belcrest Rd., Hyattsville, MD 20785

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04517

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: Mary M. Shipley
2. Dete of Death Month / Dey / Yeer: January 26, 2001
3. Time of Death: 7:50PM
4a Facility Neme *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Deeth: Montgomery

**Funeral Director**

5. Social Security Number: 321-38-3246
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: March 8, 1913
9. Birthplece *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11215 Seven Locks Road
10f. Zip Code: 20854
10g. Citizen of Whet Country?: United States

11. Marital Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 5+
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Registered Nurse
16b. Kind of Business/Industry: Public Health Nursing

17. Father's Name *(First, Middle, Last)*: Carl Smith
18. Mother's Neme *(First, Middle, Maiden Surname)*: Laura Porter

19e. Informent's Neme/Reletionship *(Type, Print)*: Edgar A. Shipley/Husband
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11215 Seven Locks Road, Potomac, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc.
Dete: Jan 29 2001
20c. Location - City or Town, Stete: Bethesda, Maryland

21. Signeture of Funeral Service Licensee: Daniel E. Perry. M00803
22. Neme and Address of Feciility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Cause (Final disease or condition resulting in death): a. SEPSIS

Due to (or es e consequenca of): HYPOTENSION

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:
b.
Due to (or es e consequenca of):
c.
Due to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contributa to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☐ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier:
29c. License number: H51200
29d. Date signed *(Month, Day, Year)*: 1-27-2001

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Anushiravan Dadgar, M.D. 13219 Executive Park Terrace, Germantown, MD 20874

**State Registrar**

31. Dete filed *(Month, Day, Year)*: JAN 29 2001
32. Registrer's Signeture: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

6

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04518

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Dena Shatenstein

2. Date of Death (Month, Day, Year): Jan. 30, 2001

3. Time of Death: 7:10P.

4a. Facility Name *(If not institution, give street and number)*: 2111 Enterprise Road

4b. City, Town, or Location of Death: Mitchellville

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 214-52-5342

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct.25,1903

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2111 Enterprise Road

10f. Zip Code: 20721

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Herman Gordon

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Berlin

19a. Informant's Name/Relationship *(Type, Print)*: Kopel Shatenstein - son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as #10a - 10g

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Adas Israel Cemetery

Date: 2/1/2001

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill RD. Beltsville, Maryland 20705

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT — 1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. HYPERTENSION — 25 years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day, Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D50343

29d. Date signed *(Month, Day, Year)*: January 31, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Kelvin Hao, M.D. 3231 Superior Lane, A-6 Bowie, Maryland 20715

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04519

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JENNIFER S. SHANKO

2. Date of Death (Month, Day, Year): JAN. 27, 2001

3. Time of Death: 6:50 PM

4a. Facility Name (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death: OLNEY

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 577-96-4943

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 12, 1960

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: TAKOMA PARK

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8001 FLOWER AVE. #1

10f. Zip Code: 20912

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): X-RAY SECRETARY

16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): FLOYD W. SHANKO

18. Mother's Name (First, Middle, Maiden Surname): DOROTHY CAROL PHILLIPS

19a. Informant's Name/Relationship (Type, Print): FLOYD W. SHANKO/FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22099 GILLIAM RD., YALE, VA. 23897

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS CREMATORY

Date: 2/1/01

20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers MO0091

22. Name and Address of Facility: 5801 CLEVELAND AVE. CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

**Physician /Medical Examiner**

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Spontaneous bacterial Peritonitis — 1 week

Due to (or as a consequence of):

c. Cirrhosis — years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acquired Immunodeficiency Syndrome

Hepatitis B

Hepatitis C

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Mendhiratta MD

29c. License number: D38262

29d. Date signed (Month, Day, Year): January 28, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DR A MENDHIRATTA 2401 Research BLVD Suite 340 Rockville MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04520

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jack Schwartz
2. Date of Death: Month Feb, Day 1, Year 2001
3. Time of Death: 3:00 pm
4a. Facility Name (If not institution, give street and number): Hebrew Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-26-1632
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 91 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 4, 1909
9. Birthplace (State or Foreign Country): Russia

Usual Residence of Decedent

10a. State: DC
10b. County: NONE
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3636 16th Street, NW Apt B543
10f. Zip Code: 20010
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Real Estate
17. Father's Name (First, Middle, Last): Unknown Schwartz
18. Mother's Name (First, Middle, Maiden Surname): Unknown Unknown
19a. Informant's Name/Relationship (Type, Print): Keith R. Schwartz, Sr. / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14205 Weeping Willow Drive, Apt 34, Silver Spring MD
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Feb 1 2001
20c. Location - City or Town, State: Alexandria, VA
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. acute cardio-pulmonary arrest
Due to (or as a consequence of):
b. Coronary artery disease
Due to (or as a consequence of):
c. metastatic prostatic carcinoma
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

s/p cerebrovascular accident
myelodysplastic syndrome
chronic cerebral ischemia
protein calorie malnutrition
Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D:44907
29d. Date signed (Month, Day, Year): Feb 1st 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CONSUELO MARANO MD 6121 Montrose Road Rockville, MD 20852

**State Registrar**

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Schwartz, Jack

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04521

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Stefana Carmelina Saglimbeni

2. Date of Death: Month January Day 28, Year 2001

3. Time of Death: 4:45P.

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-52-7412

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec.11,1913

9. Birthplace (State or Foreign Country): Italy

Usuet Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Adelphi

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1704 Lebanon Street

10f. Zip Code: 20783

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 5

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook

16b. Kind of Business/Industry: Prince George's Co. Schools

17. Father's Name (First, Middle, Last): Giovanni Giggo

18. Mother's Name (First, Middle, Maiden Surneme): Santa DiBlasi

19a. Informent's Name/Retationship (Type, Print): Deno Saglimbeni - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 14801 Eastway Street Silver Spring, Maryland 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other pieca): Gate of Heaven Cemetery

Date: 1/31/2001

20c. Location - City or Town, Stete: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Neme and Address of Fecility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Cause (Finat disease or condition resulting in deeth)

a. ACUTE MYOCARDIAL INFARCTION — 1 hr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest

b. DEMENTIA OF ALZHEIMER'S TYPE

Due to (or as a consequenca of):

c. DIABETES MELLITUS

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 8☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: M. S Nayar

29c. License number: D-17874

29d. Date signed (Month, Dey, Year): 1-29-2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): S.M. NAYAR, MD, 3717-38th AVE COTTAGE CITY, MARYLAND 20722

**State Registrar**

31. Date filed (Month, Dey, Year): FEB 01 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

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10

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend item #4a per physician 2/6/2001 mp

# Certificate of Death

Reg. No. 2001 04522

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: PATRICIA ANN STEPHENS

2. Data of Death Month Day Yaar: February 2, 2001

3. Tima of Death: 01:00PM

4a. Facility Nama *(If not institution, give street and number)*: 4401 Quillen ~~Court~~ Circle

4b. City, Town, or Location of Death: Waldorf

4c. County of Death: Charles

**Funeral Director**

5. Social Security Number: 486-34-8318

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 67 Yrs.

If Undar 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: Dec. 14, 1933

9. Birthplaca *(State or Foreign Country)*: Missouri

Usual Rasidence of Decadant

10a. Stata: Maryland

10b. County: Charles

10c. City, Town or Location: Waldorf

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 4401 Quillen Circle

10f. Zip Coda: 20602

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☒ Marriad 3☐ Widowad 4☐ Divorcad

12. Was Decadant Evar in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decadant's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; Collaga (1-4or 5+): -

16a. Decadant's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Businass/Industry: US Government

17. Fathar's Nama *(First, Middle, Last)*: Robert Shelton Harris, Sr.

18. Mothar's Nama *(First, Middle, Maidan Surnama)*: Hazel Naomi Sturman

19a. Informant's Name/Ralationship *(Type, Print)*: Ernest A. Stephens - Husband

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4401 Quillen Circle, Waldorf, MD 20602

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Trinity Memorial Gardens

Data: 2-7-01

20c. Location - City or Town, Stata: Waldorf, MD

21. Signatura of Funaral Sarvica Licansaa: Mark G. Brohawn M00053

22. Nama and Addrass of Facility: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156

**Physician /Medical Examiner**

23a. Part I. Entar tha disaasa, or complications thet causad tha daath. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or hart failura. List only ona causa on aach line.

Approximata Interval Batwaan Onsat and Daath

Immadiata Causa (Final disaasa or condition rasulting in daath)

a. RENAL CELL CANCER

Dua to (or as a consaquanca of):

Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiatad avants rasulting in daath) Last

b.

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco usa contributa to the causa of daath? 1☐ Yas 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was case rafarrad to madical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Hama 5☒ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Placa of Injury - At hama, farm, straat, factory, office building, atc. *(Specify)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28e. Data of Injury *(Month, Day Yaar)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurrad at tha tima, data and placa, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifiar: Krishan M. Mathur

29c. Licansa number: D28352

29d. Data signad *(Month, Day, Yaar)*: February 2, 2001

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Typa, Print): Krishan Mathur, M.D. P.O. Box 1703, La Plata, MD 20646

**State Registrar**

31. Data filad *(Month, Day, Yaar)*: FEB 06 2001

32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black indelible ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04523

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Winifred Young Smith
2. Data of Death — Month: January Day: 30 Year: 2001
3. Time of Death: 0233
4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 295-18-0011
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Jan. 8, 1915
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedant

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Perryville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 385 Jackson Station Road
10f. Zip Coda: 21903
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedant's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+ years
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Social Worker
16b. Kind of Business/Industry: V.A. Medical Center Perry Point, Maryland

17. Father's Name *(First, Middle, Last)*: Sanford Young
18. Mother's Name *(First, Middle, Maiden Surname)*: Genevieve Belty

19a. Informant's Name/Relationship *(Type, Print)*: Christopher M. Smith (son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3 Ivy Court, Wilmington, Delaware 19808

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other piece)*: Harford Memorial Gardens — Date: 2/1/01
20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: Thomas M. Patterson, Sr.
22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CHRONIC OBSTRUCTIVE LUNG DISEASE — 75 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION, OSTEOPOROSIS

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Suresh Dhanjani MD
29c. License number: D45344
29d. Date signed *(Month, Day, Year)*: 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURESH DHANJANI, MD, 622 S. UNION AVE, HAVRE DE GRACE, MD 21078

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: Sandra D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04524

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Woodrow Douglas Starks
2. Date of Death (Month, Day, Year): February 4 2001
3. Time of Death: 1735 P
4a. Facility Name (if not institution, give street and number): Laurelwood Care Center
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

**Funeral Director**

5. Social Security Number: 236-64-6937
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): July 8, 1942
9. Birthplece (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: North East
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 31 Darrel Road
10f. Zip Code: 21901
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laboratory Technician
16b. Kind of Business/Industry: Medical Products

17. Father's Name (First, Middle, Last): Woodrow Wilson Starks
18. Mother's Name (First, Middle, Maiden Surname): Neva Mae Cutlip

19a. Informant's Name/Reletionship (Type, Print): Charles Starks/Brother
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 3091 Turkey Point Road, North East, Maryland 21901

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Whiting Cemetery
Date: 2/8/01
20c. Location - City or Town, State: Droop, West Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset end Death |
|---|---|---|
| Immediate Ceuse (Final disease or condition resulting in deeth) | a. chronic renal failure | >1 year |
| | Due to(or es a consequence of): Diabetes | > 14 year |
| Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last | b. Due to (or as a consequenca of): | |
| | c. Due to (or as a consequenca of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: facial decub

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner steted.
29b. Signature and title of certifier: [signature]
29c. License number: D28336
29d. Date signed (Month, Dey, Year): February 5, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LINDA ENGLISH 101 E Church Road Elkton MD 21921

**State Registrar**

31. Date filed (Month, Dey, Year): FEB 06 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04525

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Sylvia L. Cunningham Shannon
2. Date of Death (Month, Day, Year): February 3, 2001
3. Time of Death: 9:52 A.M.
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 236-62-5976
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 23, 1943
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3887 Cotter Drive
10f. Zip Code: 21037
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4 yrs.
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Contract Administrator
16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: John Linton
18. Mother's Name *(First, Middle, Maiden Surname)*: Okla Graham

19a. Informant's Name/Relationship *(Type, Print)*: Malcolm L. Shannon/ Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3887 Cotter Drive Edgewater, MD 21037

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 2-3-01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ Robert Wade
22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. chronic respiratory failure — >1year
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. emphysema
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Robert T Peterson MD
29c. License number: D24504
29d. Date signed *(Month, Day, Year)*: 2/3/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert T Peterson MD 600 Ridgely Ave Annapolis md 21401

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 05 2001
32. Registrar's Signature: ▶ Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04526

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Clayton Albert Stokes, Jr.

2. Date of Death: Month January Day 31 Year 2001

3. Time of Death: 3:30 A.M.

4a. Facility Name (If not institution, give street and number): 1405 Congress Court

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 362-22-6417

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 6, 1923

9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Anne Arundel | 10c. City, Town or Location: Annapolis | 10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 1405 Congress Court | 10f. Zip Code: 21401 | 10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Automobile Distributor

16b. Kind of Business/Industry: Chrysler Corp.

17. Father's Name (First, Middle, Last): Clayton Albert Stokes, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Louisa Leona Campbell

19a. Informant's Name/Relationship (Type, Print): Alvarie Stokes/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1405 Congress Court Annapolis, MD 21401

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lakemont Meml. Gardens | Date: 2-3-01

20c. Location - City or Town, State: Davidsonville, MD

21. Signature of Funeral Service Licensee: Robert F. Mullen

22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident — 6 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Howard K Schulte Jr. MD

29c. License number: D35848

29d. Date signed (Month, Day, Year): Jan 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard K Schulte Jr. 1438 Defense Hwy. Gambrills MD 21054

**State Registrar**

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Patricia B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04527

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Catherine C. Schwab
2. Date of Death (Month, Day, Year): February 1, 2001
3. Time of Death: 10:07 A.M.
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 578-12-6188
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 29, 1915
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 209 Grey Fox Court
10f. Zip Code: 21037
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Treasury Department

17. Father's Name (First, Middle, Last): Leo Diegelmann
18. Mother's Name (First, Middle, Maiden Surname): Krescenz Konig

19a. Informant's Name/Relationship (Type, Print): Martha M. D'Angelo/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 209 Grey Fox Court Edgewater, MD 21037

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lakemont Meml. Gardens
Date: 2-3-01
20c. Location - City or Town, State: Davidsonville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: George P. Kalas Funeral Home, 2973 Solomons Island Rd. Edgewater, MD 21037

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Cardiac Arrest | 5 MINUTES |
| Due to (or as a consequence of): b. | Acute MI | 3 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D38303
29d. Date signed (Month, Day, Year): 2/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Johnston Ayscue 2003 Medical Pkway #350 - Annapolis MD 21401

**State Registrar**

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04528

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lillian P. Stanley

2. Date of Death (Month, Day, Year): January 27, 2001

3. Time of Death: 8:30 AM

4a. Facility Name (If not institution, give street and number): Sunrise Assisted Living

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 112-22-7044

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 2, 1915

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Davidsonville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 644 Ranger Court

10f. Zip Code: 21035

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): Harper Howland Prentice

18. Mother's Neme (First, Middle, Maiden Surname): Myra Lillian Dodge

19a. Informant's Name/Relationship (Type, Print): Joan M. Stanley/ Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 644 Ranger Court Davidsonville, MD 21035

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): Metropolitan Crematory

Date: 1-29-01

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure — 4 hrs

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due lo (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Asst. Living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D30718

29d. Date signed (Month, Day, Year): 1-29-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Jackson, 2003 Med. Pkwy #100, Annapolis, MD 21401

**State Registrar**

31. Date filed (Month, Day, Year): JAN 3 0 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04529

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Phi - Phi Thi Tran

2. Date of Death: Month January Day 26, Year 2001

3. Time of Death: 6:14 AM

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-86-1359

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 1, 1923

9. Birthplace (State or Foreign Country): Vietnam

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10205 Farnham Drive

10f. Zip Code: 20814

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Thuan Duc Tran

18. Mother's Name (First, Middle, Maiden Surname): Toan Thi Trinh

19a. Informant's Name/Relationship (Type, Print): Cam-Le Nguyen / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6006 Sonoma Road, Bethesda, Maryland 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cem. Date: 02/03/2001

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease — 10 years

Due to (or as a consequence of):
b. Parkinson's Disease — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Robert J. Rothstein MD

29c. License number: D34174

29d. Date signed (Month, Day, Year): 1/26/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert J. Rothstein MD 8600 Old Georgetown Rd., Bethesda, MD 20814

**State Registrar**

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Tran Phi-Phi 1/26/01 0614

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04530

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: Mary Louise Thompson
2. Dete of Deeth — Month: January Dey: 22, Yeer: 2001
3. Time of Deeth: 9:50PM
4a Facility Neme *(If not institution, give street end number)*: Holy Cross Hospital
4b. City, Town, or Location of Deeth: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Sociel Security Number: 297-32-7699
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 62 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Feb. 6, 1938
9. Birthplece *(State or Foreign Country)*: West Virgina

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5200 Crossfield Ct. #4
10f. Zip Code: 20852
10g. Citizen of Whet Country?: United States
11. Meritel Stetus: 1☐ Naver Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8; College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Neme *(First, Middle, Last)*: Lester Baber
18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Verna E. Bragg
19a. Informent's Neme/Reletionship *(Type, Print)*: Dexter Grimmett/Son
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5200 Crossfield Ct. #4, Rockville, MD 20852
20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Chesapeake Crematory
Dete: Jan. 29 2001
20c. Location - City or Town, Stete: Beltsville, MD
21. Signeture of Funerel Service Licensee: ▶ Kevin A. Moody
22. Nema and Address of Feciliy: Rapp Funeral Home & Cremation Services 933 Gist Ave., Silver Spring, MD 20910

**Physician /Medical Examiner**

23a. Pert1. Entar tha diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on eech line. — Approximete Intervel Between Onset and Death

Immediate Cause (Finel disaese or condition resulting in deeth)
e. Pneumonia — 5 days

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Lest
b. Chronic Obstructive Lung Disease — Years

Due to (or es e consequenca of):
c.

Dua to (or as e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end plece, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: ▶ Martin C Shargel M.D.
29c. License number: D08944
29d. Dete signed *(Month, Dey, Yeer)*: January 23, 2001

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Martin C. Shargel M. D. 3720 Farragut Ave., Kensington, MD 20895

**State Registrar**

31. Dete filed *(Month, Day, Year)*: JAN 31 2001
32. Registrer's Signeture: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04531

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ESTHER C. TERRELL

2. Date of Death (Month, Day, Year): JANUARY 25, 2001

3. Time of Death: 11:40PM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 578-70-4739

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Yaar: Months / Deys

If Undar 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): June 25,1952

9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 1202 First Street

10f. Zip Code: 20850

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☐ No Specify:

14. Raca - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elamentary/Secondery (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Packager

16b. Kind of Business/Industry: Mailing Co.

17. Fathar's Name (First, Middle, Last): William Hyson

18. Mother's Name (First, Middle, Maiden Surneme): June Davis

19a. Informant's Name/Reletionship (Type, Print): Larry Terrell (Husband)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1202 First St., Rockville, MD 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramovel from State 4☐ Donetion 5☐ Othar (Specify)

20b. Piece of Disposition (Name of cametery, crematory or other place): Gate of Heaven Cem.

Date: 2/1/01

20c. Location - City or Town, Stete: Silver Spring, MD

21. Signature of Funeral Service Licensee: George K. Snowden

22. Name end Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immedlete Ceuse (Final diseese or condition resulting in deeth)

e. Breast Cancer — Four Yeal

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the undertying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On tha basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and menner steted.

29b. Signatura and title of certifier: [illegible] MD

29c. Licensa number: D33686

29d. Date signed (Month, Day, Year): January 26,200[illegible]

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] Prince Phillip Dr. Olney, MD 20832

**State Registrar**

31. Dete filed (Month, Day, Year): JAN 30 2001

32. Registrer's Signeture: [illegible] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04532

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ZACHARY ROBERT TEATS

2. Date of Death Month / Day / Year: JAN 26 2001

3. Time of Death: 2:01 PM

4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 216-59-3740

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 0 Yrs. If Under 1 Year: Months 02 Days 01 If Under 24 Hrs.: Hours Min.

8. Date of Birth *(Month, Dey, Year)*: NOV 25, 2000

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: HOWARD

10c. City, Town or Location: LAUREL

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street end Number: 9620 BARREL HOUSE ROAD #H

10f. Zip Code: 20723

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 0 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: INFANT

16b. Kind of Business/Industry: NONE

17. Fether's Name *(First, Middle, Last)*: ROBERT TEATS

18. Mother's Name *(First, Middle, Maiden Sumeme)*: KIMBERLY SMOOT

19a. Informent's Name/Reletionship *(Type, Print)*: KIMBERLY N. SMOOT-TEATS/MOTHER

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 9620 BARREL HOUSE RD #H, LAUREL, MARYLAND 20723

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: NATIONAL CREMATORIUM

Date: FEB. 1, 2001

20c. Location - City or Town, State: FALLS CHRUCH, VIRGINIA

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name end Address of Fecility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death) e. EXTREME PREMATURITY

Due to (or as e consequence of):

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and manner es steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and menner stated.

29b. Signature end title of certifier ▶ Maureen Tate MD

29c. License number: MD-048338-L (PA)

29d. Date signed *(Month, Dey, Year)*: 01 29 01

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print): MAUREEN L. TATE, MAJ, MC, USA

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

**State Registrar**

31. Date filed *(Month, Day, Yeer)*: FEB 02 2001

32. Registrar's Signature ▶ Barbara B. Sparks

DHMH 16 Rev 6/95

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

6

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

2

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04533

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Nancy Beatrice Troxell

2. Date of Death (Month, Day, Year): January 26, 2001

3. Time of Death: 12:05 A.M.

4a. Facility Name *(If not institution, give street and number)*: Future Care Chespaeake

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 157-26-6875

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: March 8, 1935

9. Birthplaca *(Stata or Foraign Country)*: New York

Usual Residance of Decedant

10a. Stata: New Jersey

10b. County: Union

10c. City, Town or Location: Union

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 667 Gates Terrace

10f. Zip Coda: 07083

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yes, Giva Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grade complated)*: Elamantary/Secondary (0-12): 12th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT usa retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middla, Last)*: Arthur Otto Lange

18. Mothar's Nama *(First, Middle, Maidan Sumama)*: Gertrude Miller

19a. Informant's Name/Ralationship *(Type, Print)*: Chris Troxell/ Son

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: P.O. Box 896 Lexington Park, MD 20653

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Plece of Disposition *(Nama of camatary, cramatory or othar place)*: Metropolitan Crematory — Data: 1-26-01

20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: George P. Kalas Funeral Home, 2973 Solomons Island Rd. Edgewater, MD 21037

**Physician /Medical Examiner**

23a. Part1. Entar tha disaase, or complications that caused tha death. Do not enter the moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one causa on each lina.

Approximata Intarval Batween Onset and Death

Immediate Cause (Final disaasa or condition resulting in daath)
a. Non Hodgkins Lymphoma — 1 year

Dua to (or as a consaquance of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants rasulting in daath) Last
b.
Due to (or es e consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to tha causa of death? 1☐ Yas 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☑ No

24b. Wara autopsy findings availabla prior to complation of cause of death? 1☐ Yas 2☑ No

25. Was case rafarrad to medical examinar? 1☐ Yas 2☑ No

26. Placa of Daath *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determinad

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☑ **Certifying Physician**: To tha best of my knowladga, death occurrad at tha tima, data and placa, and dua to the ceuse(s) and manner as statad. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, death occurrad at tha tima, data and placa, and dua to tha ceuse(s) and mannar stated.

29b. Signatura and title of cartifier: ▶ John F. Loome, M.D.

29c. Licansa number: D52728

29d. Data signad *(Month, Day, Year)*: January 26, 2001

30. Nama and address of parson who completed ceusa of daath (Item 23a) (Type, Print): John F. Loome, M.D. 479 Junipers Hole Road #304 Severna Park, MD 21146

**State Registrar**

31. Data filad *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signatura: Geneva P Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04534

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Helen I. Turner
2. Date of Death (Month, Day, Year): January 27, 2001
3. Time of Death: 4:55 P.M.
4a. Facility Name (If not institution, give street and number): 3932 West Shore Drive
4b. City, Town, or Location of Death: Edgewater
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 578-40-1239
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 6, 1932
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 3932 West Shore Drive
10f. Zip Code: 21037
10g. Citizen of What Country: USA
11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Black, White, etc. Specify: White
15. Decedent's Eduction (Specify only highest grade completed): Elementery/Secondery (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home
17. Father's Neme (First, Middle, Last): Edwin Isaacson
18. Mother's Neme (First, Middle, Maiden Surneme): Ruth Leitch
19a. Informant's Neme/Reletionship (Type, Print): George G. Turner, Jr./Husband
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3932 West Shore Drive Edgewater, MD 21037
20a. Method of Disposition: 1☒ Buriat 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Lakemont Mem'l. Gardens
Date: 1-31-01
20c. Locetion - City or Town, Stete: Davidsonville, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Fecility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

mlcg

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. METASTATIC LUNG CANCER — 3 YEARS

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE; CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Yeer):
28b. Time of Injury:
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify):
28f. Location (Street end Number or Rural Route Number, City or Town, Stete):

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2☐ Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: [signature] MD
29c. License number: D16364
29d. Dete signed (Month, Dey, Yeer): 01/29/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): PETER R GRAZE MD 900 BESTGATE RD 300 ANNAPOLIS MD 21401

**State Registrar**

31. Dete filed (Month, Dey, Yeer): JAN 3 0 2001
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04535

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: William Carroll Todd
2. Deta of Death Month: 02 Day: 03 Year: 2001
3. Time of Deeth: 09:30
4a. Facility Neme *(If not institution, give street end number)*: Dorchester General Hospital
4b. City, Town, or Location of Deeth: Cambridge
4c. County of Daath: Dorchester

**Funeral Director**

5. Social Security Number: 212-12-3025
6. Sex: 1☒M 2☐F
7. Aga *(In yrs. last birthdey)*: 80 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Deta of Birth *(Month, Dey, Year)*: Nov. 15 1920
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Crocheron
10d. Inside City Limits: 1☐Yas 2☒No
10e. Street and Number: 1478 Phillips Gunning Club Road
10f. Zip Code: 21627
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐Yas 2☒No If Yes, Give Yeer or Datas:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grada completed)*: Elementery/Secondery (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: waterman
16b. Kind of Busiress/Industry: seafood industry

17. Fathar's Name *(First, Middle, Last)*: Arthur E. Todd
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Flossie B. Jones

19a. Informent's Name/Relationship *(Type, Print)*: Annabell Todd - wife
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1478 Phillips Gunning Club Rd, Crocheron, MD 21627

20a. Mathod of Disposition: 1☒Burial 2☐Cremetion 3☐Ramoval from State 4☐Donetion 5☐Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Dorchester Memorial Park
Date: 2-5
20c. Location - City or Town, Stete: Cambridge, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Nama and Addrass of Facility: Thomas Funeral Home PA, 700 Locust St., Cambridge, MD 21613

**Physician /Medical Examiner**

23a. Part I. Enter the disaasa, or complicetions thet causad tha deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth)
e. Aspiration syndrome — 1 hour
Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest
b. Due to (or es a consequence of):
c. Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.
Atherosclerotic cardiovascular disease, diabetes mellitus, cerebrovascular disease

23b. Did tobacco uee contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yas 2☒No
26. Piece of Deeth *(Check only one)*: Hospitel: 1☐Inpatient 2☒ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*
27. Menner of Deeth: 1☒Netural 2☐Accident 3☐Sulcide 4☐Homicide 5☐Pending Investigation 6☐Could not be datarmined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of exeminetion end/or invastigetion, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: [signature], MD
29c. Licensa number: D0050804
29d. Data signed *(Month, Dey, Year)*: 2-02-01

30. Nama and address of person who compiated cause of deeth (Item 23e) (Type, Print): Mark Malkus, MD 408 Byrn Street Cambridge, MD 21613

**State Registrar**

31. Deta filad *(Month, Dey, Year)*: FEB 05 2001
32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04536

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Yoshitaka Urata
2. Date of Death Month / Day / Year: January 31, 2001
3. Time of Death: 9:15 AM
4e. Facility Name *(If not institution, give street and number)*: Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

**Funeral Director**

5. Social Security Number: None
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 53 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 28, 1947
9. Birthplace *(State or Foreign Country)*: Taiwan

Usual Residence of Decedent

10a. State: Japan
10b. County: Saga
10c. City, Town or Location: Saga
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2292-2 Oaza Ogi-Machi, Kase-Machi
10f. Zip Code: 840-0862
10g. Citizen of Whet Country?: Japan

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondery (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Physician
16b. Kind of Business/Industry: Medicine

17. Father's Name *(First, Middle, Last)*: Chiang-Shan Tsai
18. Mother's Name *(First, Middle, Maiden Surneme)*: Fan-Tzu Shih

19e. Informant's Name/Relationship *(Type, Print)*: Pheng Fan Kao/Sister
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 14837 Botany Way, North Potomac, Maryland 20878

20e. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Montgomery Crematorium, Inc.
Date: Feb. 2, 2001
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funerel Service Licensee: David E Perry. M00803
22. Nama and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501

**Physician /Medical Examiner**

23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)
e. Viral Fulminant Hepatitis — 2 weeks

Due to (or as a consequence of):
b. Parotid Cancer with Metastases — 2 years

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.
Septicemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings aveileble prior to completion of ceusa of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*
Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) end manner es stated.
2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: Jonathan Heffner MD
29c. License number: RES 000
29d. Date signad *(Month, Dey, Year)*: January 31, 2001

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print): Jonathan Heffner, M.D. 600 North Wolfe Street, Baltimore, Maryland 21287

**State Registrar**

31. Date filed *(Month, Dey, Year)*: FEB 02 2001
32. Registrar's Signeture: Anne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04537

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Joseph Unger

2. Date of Death (Month, Day, Year): January 27, 2001

3. Time of Death: 10:50 PM

4a. Facility Name (If not institution, give street and number): Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 082-07-5560

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 23, 1912

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 19611 Brassie Pl.

10f. Zip Code: 20879

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Nathan Unger

18. Mother's Name (First, Middle, Maiden Surname): Sadie Posner

19a. Informant's Name/Relationship (Type, Print): Alan Unger/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Duke Ct., Rockville, MD 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Judean Memorial Gardens

Date: Jan. 30, 2001

20c. Location - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. cardiorespiratory arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last

b. Cerebrovascular accident

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☑ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D55258

29d. Date signed (Month, Day, Year): January 28, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Eaey Wilkes, M.D. 6121 Montrose Road Rockville Maryland 20852

**State Registrar**

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04538

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: DEANA Michelle Ulmer
2. Date of Death Month: JAN Day: 26 Year: 2001
3. Time of Death: 0256
4a. Facility Name *(If not institution, give street and number)*: 315 Rock Spring Court
4b. City, Town, or Location of Death: PASADENA
4c. County of Death: AA

**Funeral Director**

5. Social Security Number: 120-72-2202
6. Sex: 1☐ M 2☒ F
7. Age *(If yrs. last birthday)*: 23 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 10, 1977
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 315 Rock Spring Court
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Police Officer
16b. Kind of Business/Industry: Public Safety

17. Father's Name *(First, Middle, Last)*: David Ulmer
18. Mother's Name *(First, Middle, Maiden Surname)*: Deborah Simon

19a. Informant's Name/Relationship *(Type, Print)*: Deborah Bostick/Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8218 Wapati Court Pasadena, MD 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Asbury Town-Neck United Methodist Church Cem.
Date: Jan. 31 2001
20c. Location - City or Town, State: Severna Park, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home, 495 Gov. Ritchie Hwy. Severna Park, MD 21146

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ASPHYXIA — Due to (or as a consequence of): — minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. HANGING — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28e. Date of Injury *(Month, Day, Year)*: 1/26/01
28b. Time of Injury: UNK M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Hung Self.
28g. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Home
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: PASADENA, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: William P. Jones Deputy MD
29c. License number: D 060054
29d. Date signed *(Month, Day, Year)*: 1/26/01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): William P. Jones, MD 695 America 21035

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

mcg

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04539

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Roberta Williams
2. Date of Death (Month, Day, Year): January 29, 2001
3. Time of Death: 1020 AM
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 578-22-4753
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 12, 1911
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Reistertown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12020 Reistertown Road
10f. Zip Code: 21136
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Archiebald M. Smith
18. Mother's Name (First, Middle, Maiden Surname): Sarah A. Ferguson

19a. Informant's Name/Relationship (Type, Print): Ro-Burma Ware daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8518 Lucerne Road, Randallstown, MD 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland National Cemetery | Date: 2/3/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: André Thompson
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pneumonia — Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Parkinson's Disease, OSTEOPOROSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: V. Dixon King
29c. License number: D43453
29d. Date signed (Month, Day, Year): January 30, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): V. DIXON KING, JR, MD NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MARYLAND

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04540

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ROBERT LEWIS WILLIAMS

2. Date of Death Month / Dey / Year: Jan 28, 2001

3. Time of Death: 11:45 Am

4e. Facility Name *(If not institution, give street and number)*: 14643 Bauer Drive #220

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 323-01-8674

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept.10,1907

9. Birthplace *(State or Foreign Country)*: Florida

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14643 Bauer Drive, #220

10f. Zip Code: 20853

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yas, Giva Year or Detes: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondery (0-12): College (1-4or 5+): 3½ yrs

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Teacher

16b. Kind of Business/Industry: Education

17. Fether's Nema *(First, Middle, Last)*: Robert L. Williams

18. Mother's Name *(First, Middle, Maiden Surname)*: Lula Lowe

19e. Informent's Neme/Reletionship *(Type, Print)*: Grand-Darlene Granderson (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 14937 Ladymeade Cir., Silver Spring, MD 20906

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Funeral Serv.

Date: 1/29/01

20c. Location - City or Town, Stete: Alexandria, VA

21. Signeture of Funerel Service Licensee: George R. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final diseese or condition resulting in deeth)

a. Atherosclerotic cardiovascular disease — years

Due to (or as a consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yas 2 [X] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: Patricia L. Tomsko, MD

29c. License number: D51916

29d. Date signed *(Month, Dey, Year)*: January 28, 2001

30. Neme and address ot person who completed cause of death (Item 23a) (Type, Print): Patricia L. Tomsko, MD, 11140 Rockville Pike, PMB 348, Rockville, MD 20852

**State Registrar**

31. Dete filed *(Month, Dey, Yeer)*: JAN 30 2001

32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04541

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: NORMA BERRY WEINER

2. Data of Death — Month: JAN. Day: 26 Yaer: 2001

3. Tima of Death: 5:55AM

4a Facility Nama *(If not institution, giva street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 383-22-6893

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: OCT. 20, 1921

9. Birthplaca *(Stata or Foraign Country)*: NEW YORK

Usual Rasidence of Decedant

10a. Stata: MD

10b. County: MONTGOMERY

10c. City, Town or Location: GERMANTOWN

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 18828 SKY BLUE CIRCLE

10f. Zip Coda: 20874

10g. Citizan of What Country?: U.S.A

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☒ Widowed 4☐ Divorcad

12. Was Dacedant Evar in U,S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amaricen Indian, Black, White, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grada complatad)* — Elamantary/Secondary (0-12): ; Collaga (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retirad)*: HOMEMAKER

16b. Kind of Businass/Industry: OWN HOME

17. Fathar's Nama *(First, Middla, Last)*: LOUIS BERRY

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: ROSE KIMMELMAN

19a. Informant's Nama/Relationship *(Type, Print)*: MARK WEINER/ SON

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 18828 SKY BLUE CIRCLE, GERMANTOWN,MD 20874

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: LAKESIDE MEMORIAL PARK

Data: 1/28/2001

20c. Location - City or Town, Stata: MIAMI,FL

21. Signatura of Funaral Sarvica Licansaa: Donald C. Stottlemyer

22. Nama and Addrass of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS,INC. 1170 ROCKVILLE PIKE,ROCKVILLE,MD 20854

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications thet ceused tha daath. Do not antar tha mode of dying, such es cardiac or respiretory arrest, shock, or haart failura. List only one ceuse on aach lina.

Approximata Intarval Batwaen Onset and Death

Immediate Cause (Final diseese or condition rasulting in daath)
a. CEREBROVASCULAR ACCIDENT — YRS.

Due to (or as a consaquance of):
b. CIRRHOSIS — YRS.

Sequantially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Cause (Disease or injury thet initieted evants rasulting in death) Last

Due to (or as a consaquance of):
c. HYPERTENSION — YRS.

Due to (or as a consaquance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco usa contribute to the causa of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of causa of daath? 1☐ Yas 2☒ No

25. Was cesa rafarrad to madical axaminar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifier: S.G. Rao MD

29c. Licansa number: D35792

29d. Data signed *(Month, Day, Year)*: JANUARY 26, 2001

30. Nama and addrass of person who completed ceuse of daath (Item 23a) (Type, Print): SWAROOP G. RAO MD 50 W. EDMONSTON DR.#504, ROCKVILLE,MD 20852

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signatura: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend #10a-f,2/5/2001,BMW,Montg.Co

# Certificate of Death

Reg. No. 2001 04542

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Frederick W. Wieslander

2. Data of Death — Month: January Day: 26 Year: 2001

3. Time of Death: 21:15

4e. Facility Nama (If not institution, giva street and number): 15302 Chinaberry Street

4b. City, Town, or Location of Deeth: North Potomac

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 572-24-9705

6. Sax: 1 [X] M 2 [ ] F

7. Aga (In yrs. last birthday): 74 Yrs.

If Under 1 Yaar — Months: Days:

If Undar 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Dey, Year): May 7, 1926

9. Birthplaca (Stata or Foraign Country): California

Usuel Residence of Decedant

10a. Stata: Maryland ~~Texas~~

10b. County: Montgomery ~~Harris~~

10c. City, Town or Location: North Potomac ~~Houston~~

10d. Insida City Limits: ~~1 [X] Yes~~ 2 [X] No

10e. Street and Number: 15302 Chinaberry Street ~~2115 Lander Lane~~

10f. Zip Coda: 20878 ~~77057~~

10g. Citizan of What Country?: United States

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Give Yaar or Datas: World War II Korea

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - Americen Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed)

Elamentary/Secondary (0-12):

College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): Consultant

16b. Kind of Business/Industry: Petroleum Equipment Industry

17. Father's Nama (First, Middla, Last): Frederick Gutwein

18. Mothar's Nama (First, Middla, Maidan Sumama): Elizabeth Rice

19a. Informent's Name/Ralationship (Type, Print): Leslie W. Rosenthal/Daughter

19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 15302 Chinaberry Street, North Potomac, Maryland 20878

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): Montgomery Crematorium, Inc.

Date: January 27, 2001

20c. Location - City or Town, Stata: Bethesda, Maryland

21. Signature of Funeral Service licensee: David Perry M00803

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

**Physician /Medical Examiner**

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not anter tha mode of dying, such es cerdiac or respiratory arrast, shock, or heert feilure. List only ona ceuse on each lina.

Approximate Intarval Between Onset end Death

Immediete Cause (Final disaasa or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease — Years

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immadiata ceuse. Entar Underlying Cause (Diseasa or injury that initiated evants resulting in death) Lest

b.

Dua to (or as a consequance of):

c.

Due to (or es e consequance of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying ceusa givan in Part I.

23b. Did tobacco usa contributa to tha causa of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings availabla prior to compiation of causa of death? 1 [ ] Yas 2 [ ] No

25. Wes cesa refarred to medical examiner? 1 [ ] Yas 2 [X] No

26. Placa of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [X] Othar (Specify) Daughter's Residence

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha ceusa(s) and mannar as stated. 2 [ ] **Medical Examiner**: On tha basis of examination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: Joseph A Ball

29c. Licensa number: 53317

29d. Data signad (Month, Day, Year): January 31, 2001

30. Nama and address of person who complated ceusa of daath (Item 23a) (Type, Print): Joseph A. Ball, M.D. 16220 Frederick Road, Suite 213, Gaithersburg, Maryland 20877

**State Registrar**

31. Data filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Sandra B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04543

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Rose Villareale
2. Date of Death (Month, Day, Year): January 26, 2001
3. Time of Death: 7:45 pm
4a. Facility Name *(If not institution, give street and number)*: Villa Rosa Home
4b. City, Town, or Location of Death: Mitchellville
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 052-12-7082
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec 13, 1906
9. Birthplace *(State or Foreign Country)*: Sicily

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Mitchellville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3800 Lottsford Vista Road
10f. Zip Code: 20721
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Luigi Torregrossa
18. Mother's Name *(First, Middle, Maiden Surname)*: Liuzzo Concetta Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Faust C. Villareale/ Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 504 Castleray Circle, Ft. Washington, MD 20744

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: Jan 30 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Faith L. Brunell
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Pneumonia | weeks |
| Due to (or as a consequence of): | | |
| b. | Failure to thrive | months |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Dementia | years |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Richard J. Feldman MD
29c. License number: D32261
29d. Date signed *(Month, Day, Year)*: 1-29-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard J. Feldman MD 9500 Annapolis rd Lanham MD 20706

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

3-1-02 JAB
AMEND ITEM#10g&13 PER INFMNT. G805

# Certificate of Death

Reg. No. 2001 04544

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Carlos G. Vidalon | January 23, 2001 | 11:40 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Manor Care Potomac | Potomac | Montgomery |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-92-2890 | 1☒ M 2☐ F | 77 Yrs. | | | March 1, 1923 | Peru |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Montgomery | Potomac | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8836 Tuckerman Lane | 20854 | PERU ~~United States~~ |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | XX 1☐ Yes 2☒ ~~No~~ Specify: PERUVIAN | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Agricultural Engineer | World Bank |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Pablo Vidalon | Maria Luisa Gandolini |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ida M. Vidalon/Wife | 8836 Tuckerman Lane, Potomac, Maryland 20854 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Gate of Heaven Cemetery | Jan. 27 2001 | Silver Spring, Maryland |

| 21. Signature of Funeral Service Licensee | | 22. Name and Address of Facility |
|---|---|---|
| ▶ [signature] | M00198 | Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Cardio-Respiratory Failure | 2 Hours |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Sepsis | 2 Hours |
| Due to (or as a consequence of): | | |
| | c. Pneumonia | Hours |
| Due to (or as a consequence of): | | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | D29256 | January 23, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jose A. Quiros, M.D. 4343 Montgomery Avenue, Bethesda, Maryland 20814-4416

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JAN 29 2001 | ▶ [signature] G. Spaks |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
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**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0527-003

LINDA WASHKO

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend #4c, 2/6/2001, BMW, Montg.Co

# Certificate of Death

Reg. No. 2001 04545

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| LINDA TANSILL WASHKO | JANUARY 31, 2001 | 11:12A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 738 SONNE DRIVE | ANNAPOLIS | ANNE ~~ARUNDEL~~ ARUNDEL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-76-5274 | 1☐M 2☒F | 43 Yrs. | | | Sept 21, 1957 | DC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Annapolis | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 738 Sonne Drive | 21401 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Space Planner | Federal Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| Robert Tansill | Janet S. Goetz |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Robert C. Tansill / Father | 9704 Braddock Road, Silver Spring, MD 20903 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Name of cemetery, crematory or other place) | Dete | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gate of Heaven Cemetery | Feb 5 2001 | Silver Spring, MD |

21. Signature of Funerel Service Licensee ▶ James E Dooley

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in death) | a. BLUNT FORCE INJURIES OF THE HEAD | |
| Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last | Due to (or as e consequence of): b. | |
| | Due to (or es e consequence of): c. | |
| | Due to (or as e consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Wes case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined | 1/31/01 FOUND | 1100 A M | 1☐Yes 2☒No | SUBJECT WAS STRUCK ON THE HEAD WITH A BLUNT OBJECT |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AT HOME | | | 28f. Location (Street end Number or Rural Route Number, City or Town, State) 738 SONNE DRIVE ANNAPOLIS, MD |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Yeer) |
|---|---|---|
| ▶ M.D | O.C.M.E. | FEBRUARY 1, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Dey, Yeer) | 32. Registrar's Signature |
|---|---|
| FEB 02 2001 | G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

RKD

01-0595-015

JOHN WATSON

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04546

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): J. Morrison Watson
2. Date of Death (Month, Day, Year): FEBRUARY 3, 2001
3. Time of Death: 2:03P. M
4a. Facility Name (If not institution, give street and number): 607 BIDDLE STREET
4b. City, Town, or Location of Death: CHESAPEAKE CITY
4c. County of Death: CECIL

**Funeral Director**

5. Social Security Number: 216-09-0688
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 24, 1918
9. Birthplace (State or Foreign Country): Maryland

Usuet Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Chesapeake City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 607 Biddle Street
10f. Zip Code: 21915
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber
18b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): James B. Watson
18. Mother's Name (First, Middle, Maiden Surneme): Laura Donaldson

19a. Informant's Name/Relationship (Type, Print): Sandra F. Tracy/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2506 Rocks Rd., Forest Hill, MD 21050

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Bethel Cemetery
Date: 2-6-2001
20c. Location - City or Town, State: Chesapeake City, MD

21. Signeture of Funeral Service Licensee: [signature]
22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 318 George Street, Chesapeake City, MD 21915

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart lailure. List only one cause on each line. (Approximate Interval Between Onset end Death)

Immediate Cause (Final disease or condition resulting in death): a. ~~Arteriosclerotic Cardiovascular Disease~~

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnency 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24e. Was an autopsy performed? [illegible] 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case relerred to medical examiner? 1 [X] Yes 2 [ ] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Dey, Year): FEBRUARY 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04547

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Donald A. Whittam

2. Date of Death (Month, Day, Year): FEBRUARY 2 2001

3. Time of Death: 10:25 AM

4a. Facility Name (If not institution, give street and number): Doctor's Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 113-16-0137

6. Sex: 1 XX M 2 ☐ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 7, 1926

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 13215 Chestnut Drive

10f. Zip Code: 20720

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Yeer or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Communications Specialist

16b. Kind of Business/Industry: Nat'l. Security Agency

17. Father's Neme (First, Middle, Last): Alfred Whittam

18. Mother's Name (First, Middle, Maiden Surname): Margaret Schmidt

19a. Informant's Name/Relationship (Type, Print): Marjorie A. Whittam/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13215 Chestnut Drive Bowie, Maryland 20720

20a. Method of Disposition: 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lakemont Mem'l. Gardens

Date: 2-6-01

20c. Location - City or Town, State: Davidsonville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiac Arrest

Due to (or as a consequence of): Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of): Diabetes Mellitus

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en eutopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D19446

29d. Date signed (Month, Day, Year): 02/02/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Remsen MD 575 Main Street Suite 253 Laurel MD 20707

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

WHITTAM, DONALD

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04548

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: JANET B. WHARTON

2. Date of Death (Month / Day / Year): JAN 28, 2001

3. Time of Death: 3:00 AM

4a. Facility Name *(If not institution, give street and number)*: ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

**Funeral Director**

5. Social Security Number: 219-36-5212

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 14 1938

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: SEVERNA PARK

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 83 HOYLE LANE

10f. Zip Code: 21146

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4 or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE

16b. Kind of Business/Industry: NONE

17. Father's Name *(First, Middle, Last)*: JOHN BATES

18. Mother's Name *(First, Middle, Maiden Surname)*: THELMA BELSON

19a. Informant's Name/Relationship *(Type, Print)*: PEARL JACKSON (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 83 HOYLE LANE SEVERNA PARK, MD. 21146

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CARPENTER HILL CEME.

Date: 2/3/01

20c. Location - City or Town, State: ROUND BAY, MD.

21. Signature of Funeral Service Licensee: ▶ Larry G. Reese MO0483

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ACUTE HEMORRHAGE FROM AORTOESOPHAGEAL FISTULA — 3 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ James M. Blake MD BLAKE STAFF PHYSICIAN

29c. License number: D-20543

29d. Date signed *(Month, Day, Year)*: JANUARY 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES M. BLAKE, MD 171 DEFENSE HIGHWAY ANNAPOLIS 21401

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04549

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): Mary Andy
2. Dale of Death — Month: February Day: 13 Year: 2001
3. Time of Death: 9:30 A.M.
4a Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 381-10-7544
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dale of Birth (Month, Day, Year): 04/15/1916
9. Birthplace (State or Foreign Country): Vermont

Usual Residence of Decedent

10e. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 126 N. Rose St.
10f. Zip Code: 21224
10g. Citizen of Whet Country?: USA
11. Maritel Stalus: 1☐Never Married 2☐Merried 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yea 2☒No If Yes, Give Year or Dales:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indien, Black, White, etc. Specify: White
15. Decedent's Educelion (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Antoni Krupski
18. Mother's Name (First, Middle, Maiden Surname): Barbara Pakuszta
19a. Informent's Neme/Relalionship (Type, Print): Genevieve Greenslade
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 41555 S.Belleridge DR APT 622 Belleville, MI 48111
20a. Method of Disposition: 1☒Burial 2☐Cremalion 3☐Removal from Slale 4☐Donelion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer Cem.
Dele: 02/17/01
20c. Locelion - City or Town, Stale: Baltimore, MD
21. Signature of Funeral Service licensee: Peter D. Ashton MD011
22. Name end Address of Fecility: Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring RD Baltimore, MD 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused lhe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediete Cause (Final diseese or condilion resulting in death): a. Myocardial Infarction
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Congestive Heart Failure
Due to (or es e consequence of):
c. Atrial Fibrillation
Due lo (or as e consequence of):
d.

Part II. **Other significant conditions** contributing lo death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uee contributa to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred lo medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one) — Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Dele of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dele and place, and due to the ceuse(s) end manner es slated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Nina F Everett, MD
29c. License number: D46444
29d. Dale signed (Month, Day, Year): Feb. 15, 2001

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print): 2323 Orleans St, Baltimore MD 21224, Dr. Nina F. Everett

**State Registrar**

31. Dale filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,b per md G792 2/16/01 yf

*Certificate of Death*

Reg. No. 2001 04550

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MADELINE ALBERTI

2. Data of Death Month / Day / Yaar: FEBRUARY 2 2001

3. Tima of Death: 1858

4a Facility Nema *(If not institution, giva street and number)*: JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 069-12-3872

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Dec. 17, 1906

9. Birthplace *(State or Foreign Country)*: Md.

Usual Rasidence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Streel and Number: 406 S. Robinson St.

10f. Zip Coda: 21224

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Americen Indian, Black, Whita, alc. *Specify:* White

15. Decedant's Educetion *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usuel Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Secretary

16b. Kind of Business/Industry: Equitable Life

17. Father's Name *(First, Middla, Last)*: Joseph F. Bachta

18. Mothar's Nama *(First, Middla, Maiden Sumama)*: Margaret Dienstbier

19a. Informant's Name/Ralationship *(Type, Print)*: Mrs. Olivia Seabolt/daughter

19b. Mailing Addrass *(Sraet and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 278 Morris Rd. Fawn Grove, Pa. 17321

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemafary, cramatory or othar placa)*: Parkwood Cemetery

Data: 2/6/01

20c. Location - City or Town, Stata: Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

**Physician /Medical Examiner**

23a. Part1. Enter the disaase, or complications that ceusad the death. Do not enter tha moda of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only ona causa *on* aach lina.

Approximata Intarval Batween Onsat and Daath

Immediata Causa (Final disaasa or condition resulting in death)

a. RENAL FAILURE — TWO DAYS

Dua to (or as a consequence of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last

b. HYPERKALEMIA

Dua to (or as a consequence of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Other sfgnifficant conditions** contributing to daath but not rasulting in tha undarlying ceusa given in Part I.

23b. Dfd tobacco use contributa to the causs of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Wes case rafarred to medicel axaminar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha time, data and place, and dua to tha ceusa(s) end manner as stated. 2☐ **Medicaf Examinar:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and place, and dua to tha cause(s) and mannar statad.

29b. Signatura and title of certifier: MD

29c. Licanse number: RES 000

29d. Date signad *(Month, Day, Year)*: FEBRUARY 2 2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): SAPTARSI HALDAR 600 N WOLFE ST BALTIMORE MD 21287

**State Registrar**

31. Dete filed *(Month, Day, Year)*: F FEB 16 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04551

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Olga Myrtle Booth
2. Date of Death (Month, Day, Year): FEB. 15, 2001
3. Time of Death: 10:50am
4a. Facility Name (If not institution, give street and number): 7535 Browns Bridge Road
4b. City, Town, or Location of Death: Highland
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 212-24-4919
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 1, 1914
9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Highland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7535 Browns Bridge Road
10f. Zip Code: 20777
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Carl Michael Misenko
18. Mother's Name (First, Middle, Maiden Surname): Mary Magdeline Salenko

19a. Interment's Name/Relationship (Type, Print): William Charles Booth/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7535 Browns Bridge Road Highland, MD 20777

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 2/16/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ David P. McDonald
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CEREBROVASCULAR ACCIDENT — YEARS

Due to (or as a consequence of):
b. Essential Thrombocythemia — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: 35635
29d. Date signed (Month, Day, Year): FEBRUARY 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Kaplan, MD 13111 Prince Phillip Dr. OLNEY, MD 20832

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: ▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No 2001 04552

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Norma Bright

2. Date of Death Month: 2 Day: 13 Year: 01

3. Time of Death: 11:00 AM

4a. Facility Name (If not institution, give street and number): Lorien Frankford Nursing Home

4b. City, Town, or Location of Death: Balto, md

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 212-46-2122

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06-29-36

9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1252 E. North Avenue

10f. Zip Code: 21202

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decadent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10th Grade

College (1-4or 5+): NA

16a. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Day Care Provider

16b. Kind of Business/Industry: Day Care

17. Father's Name (First, Middle, Last): Milton Johnson

18. Mother's Name (First, Middle, Maiden Surname): Loretta Brown

19a. Informant's Name/Relationship (Type, Print): William Loretta Bollings+ Bright

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1252 E. North Avenue Baltimore, Maryland 21202

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest VA Cem. Date: 02-20-2001

20c. Location - City or Town, State: Owings Mills MD

21. Signature of Funeral Servica Licansee: Francis D Green

22. Name end Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death): a. Cerebrovascular accident — one day

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other aignificant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Chronic renal failure

23b. Did tobecco use contribute to the cauae of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and menner es steted. 2☐ **Medical Examiner**: On the besis of examination and/or investigetion, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Chi-Shiang Chen MD

29c. License number: D-18151

29d. Date signed (Month, Day, Year): 2-13-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CHI-SHIANG CHEN 301 ST. PAUL PLACE BALTIMORE MD 21202

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requiras that tha daath certificata be axecuted within 24 hours after daath.

**To the Funeral Director:** After this certificate has been signed by tha attanding physician and completely filled in by tha funaral director, paga 2 should be detached for usa as tha burial-transit

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04553

Biederski, Edward 9:15PM 2/14/01
Baltimore, Maryland 21215-0020

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Edward Biederski | February 14, 2001 | 9:15 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Esther's Place | Terrace | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-03-2568 | 1☒M 2☐F | 89 Yrs. | | | Aug 30, 1911 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Insida City Limits |
|---|---|---|---|
| MD | Baltimore | Dundalk | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8206 N. Boundary Road | 21222 | United States |

| 11. Marital Status | 12. Was Decedent Evar in U.S. Armed Forcas? | 13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) | 14. Race - American Indian, Black, White, efc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yas 2☒No If Yes, Give Year or Dates: | 1☐Yas 2☒No Specify: | Specify: White |

| 15. Decedent's Educetion (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 6 | | Engraver | Newspaper |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Victor Biedrzycki | Connie (Unknown) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Thaddeus Biedrzycki /Brother | 8206 N. Boundary Road, Dundalk, MD 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | Feb 17 2001 | Beltsville, MD |

| 21. Signature of Funaral Sarvice Licensee | 22. Name and Address of Facility |
|---|---|
| Laura C. Handley | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury fhat initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due fo (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death buf nof resulting in the underlying ceusa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐**Yes** 2☐**No** 3☐**Probably** 4☒**Unknown**

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yas 2☒No | 1☐Yes 2☐No |

| 25. Was cese referred to medicel exeminer? | 26. Piece of Deeth (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Ass. Living |

| 27. Manner of Death | 28a. Data of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at tha fima, data and place, and dua fo the cause(s) and mannar as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Laura C. Hand MD | D38033 | 2/15/01 |

30. Nama and address of person who compiated causa of daath (Item 23d) (Type/Print)
I. BANAS 261 S. Bylvland Ave Baltimore, MD 21224

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after daath.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral diractor, page 2 should be datached for usa as tha burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiena.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

$7
3

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | D. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 04554

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| MARY BERCSI | FEBRUARY 14, 2001 | 12:45 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GREATER BALTIMORE MEDICAL CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 210-36-7829 | 1☐ M 2☒ F | 98 Yrs. | — / — | — / — | Jan. 30, 1903 | Hungary |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Baltimore | Towson | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 903 Breezewick Rd | 21286 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | Homemaker | Homemaker |
| 12 | | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Arpad Rosemberzky | Erma Nemtudom |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Marianne von Rigler / Daughter | 820 Stags Head Rd. Towson, Md 21286 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Greenmount Cemetery | February 16, 2001 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Laura C. Wardesty | CAFA - Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 7 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M.D. | D52197 | 02-14-2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
REKHA MOTAGI GBMC 6701 N. CHARLES ST., BALTIMORE, MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Bercsi, Mary
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04555

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: CATHERINE BETTIS

2. Date of Death Month: FEB Day: 11 Year: 2001

3. Time of Death: 1020 pm

4a. Facility Name *(If not institution, give street end number)*: HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

**Funeral Director**

5. Social Security Number: 579-26-6840

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG 15, 1920

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9230 Traders Crossing, Apt. N

10f. Zip Code: 20723

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: School System

17. Father's Name *(First, Middle, Last)*: Charles Blair

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Anna Scott

19a. Informant's Name/Reletionship *(Type, Print)*: Reginald Blair/nephew

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 9230 Traders Crossing Apt N, Laurel, MD 20723

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Placa of Disposition *(Neme of cemetery, cremetory or other piece)*: Mt. Canaan Baptist Church Cemetery

Date: 2/17/01

20c. Location - City or Town, Stete: Trenton, SC

21. Signature of Funeral Service Licensee: Daniel Simons

22. Name end Address of Facility: G.L. Brightharp & Sons Funeral Home, 614 West Ave., N. Augusta, SC 29841

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. SEPTIC SHOCK — DAYS

Due to (or as a consequence of):

b. UROSEPSIS

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

HYPERTENSION

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yss 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) end manner stated.

29b. Signeture and title of certifier: FRANCIS CHUIDIAN MD

29c. License number: D42892

29d. Date signed *(Month, Dey, Year)*: FEB 12 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS CHUIDIAN 10724 LITTLE PATUXENT PARKWAY, COLUMBIA MD 21044

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature: Linda D. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04556

ELMER BUTLER

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Elmer G. Butler
2. Date of Death (Month, Day, Year): February 12 2001
3. Time of Death: 1510
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 216-17-1442
6. Sex: XX 1 ☐ M 2 ☐ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 21, 1923
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Odenton
10d. Inside City Limits: 1 ☐ Yes XX 2 ☐ No
10a. Street and Number: 1225 B Scotts Manor Court
10f. Zip Code: 21113
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married XX 3 Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes XX 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner-Operator
16b. Kind of Business/Industry: Carpet Cleaning

17. Father's Name (First, Middle, Last): William F. Butler
18. Mother's Name (First, Middle, Maiden Surname): Louise Kelly

19a. Informant's Name/Relationship (Type, Print): Michael Butler (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 908 Crigger Road, Gambrills, MD 21054

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crametory or other piece): Bethel Cemetery
Data: 02/15 2001
20c. Location - City or Town, State: Ft. Meade, MD

21. Signature of Funeral Service Licensee: Patrick J. Hardesty
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE
Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending investigation 6 ☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D43977
29d. Date signed (Month, Day, Year): February 12 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Baker Brenizer. 301 Hospital Drive. Glen Burnie. MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: Barbara G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04557

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: CHARLIE L. BOOTHE

2. Date of Death Month / Day / Year: FEBRUARY 12, 2001

3. Time of Death: 6:43 PM

4a. Facility Name *(If not institution, give street and number)*: 3722 Fairhaven Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 227-28-8512

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 25 1927

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3722 Fairhaven Avenue

10f. Zip Code: 21226

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1946-1947

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Improvements

16b. Kind of Business/Industry: Contracts

17. Father's Name *(First, Middle, Last)*: J. E. Boothe

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Holbrook

19a. Informant's Name/Relationship *(Type, Print)*: Maryland Anatomy Board

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: VARO Regional Office 31 Hopkins Plaza, Balto, MD 21201

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cem.

Date: Feb. 16 2001

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD. 21122

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Atherosclerotic — 1/94

Due to (or as a consequence of): Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer with Metastasis

Resected Colon Cancer

Severe Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D31744

29d. Date signed *(Month, Day, Year)*: 2/15/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G. HEBARD, M.D. 4710 Pennington Ave. Baltimore, MD. 21226

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04558

Physician /Medical Examiner

Funeral Director

1. Decedent's Name *(First, Middle, Last)*: Frances F. Bednego

2. Data of Death — Month: February; Day: 14; Yaar: 2001

3. Tima of Death: 1242

4a Facility Name *(If not institution, give street and number)*: Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

5. Social Security Number: 337-24-2858

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Yaar — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Dey, Year)*: 9-8-1930

9. Birthplaca *(Stata or Foraign Country)*: KY

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 952 Redfield Court Apt. A

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Billing Clerk

16b. Kind of Businass/Industry: Health Care Management

17. Father's Nama *(First, Middle, Last)*: Marvin Laffoon

18. Mothar's Name *(First, Middla, Maidan Surnama)*: Flossie McClary

19a. Informant's Name/Relationship *(Type, Print)*: Connie Leslie/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 1917 Munsey Drive Forrest Hill MD 21050

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or other place)*: Oaklawn Cemetery

Data: 2/17/01

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21237

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified and once.**

**To Be Completed by Funeral Director**

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Batween Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Intracranial Hemorrhage — 24 hours

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Cerebral Herniation

HTN

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Numbar, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, date and place, and dua to tha causa(s) and mannar es statad. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and piece, end dua to the causa(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D53462

29d. Data signed *(Month, Day, Year)*: 2/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jude Muneses MD 7845 Oakwood Road Glen Burnie, MD 21061

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Bednego, Frances F

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04559

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOAN BEALL
2. Date of Death: Month Feb Day 14 Year 2001
3. Time of Death: 5:52 Am
4a. Facility Name (If not institution, give street and number): ST. AGNES HEALTHCARE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-32-0574
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 1, 1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3583 Benzinger Road
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bank Teller
16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): John Adam Lewrenz
18. Mother's Name (First, Middle, Maiden Surname): Ethel Mary Moran

19a. Informant's Name/Relationship (Type, Print): David M. Beall / son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 637 Plymouth Road Baltimore, MD 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Lake View Memorial Park
Date: 02/17/01
20c. Location - City or Town, State: Eldersburg, MD

21. Signature of Funeral Service Licensee: George E. MacNabb
22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in death) | e. HYPOXIC ENCEPHALOPATHY | DAYS |
| | Due to (or es e consequence of): BREAST CANCER | YEARS |
| Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last | b. | |
| | Due to (or es e consequence of): | |
| | c. | |
| | Due to (or es e consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: P. Bonnie MD
29c. License number: P 13595
29d. Date signed (Month, Day, Year): Feb 14 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE BAFFOE-BONNIE. ST. AGNES HOSPITAL

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signeture: Ginger D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Joan Mary Beall D.O.D. - 2/14/01

NAME JOAN BEALL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04560

AMEND#26 PER MD. G792 2-16-2001 JAB

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Irene E. Bradford
2. Date of Death Month Day Year: Feb 8, 2001
3. Time of Death: 1:24 a.m.
4a. Facility Name (If not institution, give street end number): 254 Sharpe Town South
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 214-09-3028
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. If Under 1 Year Months Days / If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year): Jul 22, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: PA
10b. County: Franklin
10c. City, Town or Location: State Line
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 778 Carl Circle
10f. Zip Code: 17263
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home
17. Fether's Name (First, Middle, Last): Dwight Gabe
18. Mother's Name (First, Middle, Maiden Surneme): Alberta Six
19a. Informant's Name/Reletionship (Type, Print): Ms. Cynthia Grayson
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 254 Sharpe Town South Laurel, MD 20724
20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): All County Cremation Services, Inc.
Date: 02/09/01
20c. Location - City or Town, State: Sykesville, Maryland
21. Signature of Funeral Service Licensee: [signature] M00535
22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Cause (Final disease or condition resulting in death)
a. End Stage Coronary Artery Disease — months

Due to (or as a consequence of):
b. Arteriosclerosis — months

Sequentially fist conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
Due to (or es e consequence of):
c. Hyperlipidemia — months

Due to (or as a consequence of):
d. COPD — years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Carotid Stenosis
Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medicel exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) DAUGHTER'S HOME

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the ceuse(s) and menner stated.
29b. Signature end title of certifier: Richard Kolodrubetz
29c. License number: D31575
29d. Date signed (Month, Dey, Year): February 8, 2001
30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Richard Kolodrubetz, M.D. 9501 Old Annapolis Rd. Ellicott City MD 21042

**State Registrar**

31. Date filed (Month, Dey, Year): FEB 16 2001
32. Registrer's Signeture: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04561

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOSEPH E. BUCHTA, JR
2. Date of Death (Month, Day, Year): February 12 2001
3. Time of Death: 11:02 AM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 218-62-2597
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 12, 1953
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md
10b. County: BALTIMORE
10c. City, Town or Location: TIMONIUM, Md.
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2013 REUTER Rd
10f. Zip Code: 21093
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRIVATE INVESTIGATOR
16b. Kind of Business/Industry: HARFORD Co.

17. Father's Name (First, Middle, Last): JOSEPH E. BUCHTA, SR.
18. Mother's Name (First, Middle, Maiden Surname): BARBARA WEIGLE

19a. Informant's Name/Relationship (Type, Print): ELAINE BUCHTA
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2013 REUTER Rd. TIMONIUM, Md. 21093

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT CREM. | Date: 2/19/01
20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensee: Paul M. Stella
22. Name and Address of Facility: HARTLEY MILLER FUNERAL HOME, CHTD. 7527 HARFORD Rd - BALTO. Md. 21234

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Venous Air Embolism | 2 hours |
| Due to (or as a consequence of): b. | Neurofibromatosis | 47 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Dural Ectasia | 47 years |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Spinal Instability
Spondyloptosis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Melanie B. Kinchen, MD
29c. License number: BK68284 16
29d. Date signed (Month, Day, Year): February 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 601 N. Caroline St. JHOC-5 Baltimore, MD 21287

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04562

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Donald Clinton

2. Data of Death — Month: FEB Day: 13 Year: 2001

3. Time of Death: 06 54 AM

4e. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 219-30-6990

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 09/26/1935

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10e. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2926 Edgecombe Cir, South

10f. Zip Code: 21215

10g. Citizen of What Country?: NA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* AFRICAN AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): NA

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: GROOMSMAN

16b. Kind of Business/Industry: RACETRACK

17. Father's Name *(First, Middle, Last)*: JOHN ELMER CLINTON

18. Mother's Name *(First, Middle, Maiden Surname)*: VICTORIA READDY

19e. Informant's Name/Relationship *(Type, Print)*: PHYLLIS FORD (SISTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2926 EDGECOMB CIRCLE SOUTH BALTIMORE MD 21215

20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: KING MEMORIAL PARK

Date: 2/19/01

20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA
638 N. GILMOR STREET BALTIMORE, MD 21217

To Be Completed by Funeral Director

CLINTON, DONALD
219-30-6990
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASCVD - Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. END STAGE RENAL DISEASE

Due to (or as a consequence of):
c. HYPERTENSION

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PRIOR MYOCARDIAL INFARCTION
COPD, CVA,

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D31704

29d. Date signed *(Month, Day, Year)*: FEB 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAT WIEBER MD MGH EMERGENCY DEPT

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Amended Item#21,22 perABG792 2/16/2001 EW

2001 04563

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): JESUS COLON

2. DATE OF DEATH (Month, Day, Year): 02 13 01

3. TIME OF DEATH: 0110 M

4. SOCIAL SECURITY NUMBER: unk

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): unk YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.

7. DATE OF BIRTH (Month, Day, Year): unk

8. BIRTHPLACE (State or Foreign Country): Puerto Rico

9a. FACILITY NAME (If not institution, give street and number): ECI Prison

9b. CITY, TOWN OR LOCATION OF DEATH: Westover

9c. COUNTY OF DEATH: Somerset

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: Somerset

10c. CITY, TOWN OR LOCATION: Westover

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 30420 Revels Neck Road

10f. ZIP CODE: 21890

10g. CITIZEN OF WHAT COUNTRY?: Puerto Rico

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [X] YES 2 [ ] NO Specify: Puerto Rican

14. RACE — American Indian, Black, White, etc.
Specify: Hispanic

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): unk
College (1-4 or 5 +): unk

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): unk

16b. KIND OF BUSINESS/INDUSTRY: unk

17. FATHER'S NAME (First, Middle, Last): Ramone Vasquez

18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Ortiz

19a. INFORMANT'S NAME (Type/Print): Benny Colon/brother

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): unk

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) | DATE

20c. LOCATION — City or Town, State

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] Ronald S Wade DIRECTOR PER DVR

22. NAME AND ADDRESS OF FACILITY: State Anatomy Board 655 W Baltimore ST Baltimore,Md 21201

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Liver Cirrhosis — 1 month

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hepatitis C infection — 1 year

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Hypertension

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) Prison Infirmary

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: D0050826

29d. DATE SIGNED (Month, Day, Year): 2-13-01

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
30 ISAAC A ENIOLA MD 30420 Revell's Neck RD Westove MD 21890

31. DATE FILED (Month, Day, Year): FEB 16 2001

32. REGISTRAR'S SIGNATURE: Geneva B. Sparks

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04564

Letha Chamblain

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

## Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Letha Chamblain
2. Date of Death (Month, Day, Year): FEBRUARY 15 2001
3. Time of Death: 6:39 AM
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

## Funeral Director

5. Social Security Number: 220-14-8179
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-14-17
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street end Number: 1508 Lakeside Avenue
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): 2nd Grade
College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Court Square Restaurant

17. Father's Name (First, Middle, Last): Ernest Kirkman
18. Mother's Name (First, Middle, Maiden Sumame): Francis Williams

19a. Informant's Neme/Reletionship (Type, Print): Ernestine Addison
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21218: 1508 Lakeside Avenue Baltimore, Maryland

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cemetery, cremetory or other piece): Arbutus Mem. Pk. Cem.
Date: 02-19-01
20c. Location - City or Town, State: Arbutus, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

## Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. SEPSIS — 2 DAYS

Due to (or es e consequence of):
b. URINARY TRACT INFECTION — UNKNOWN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE
HEPATIC FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner es stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) and menner stated.

29b. Signatura and title of certifier: ▶ [signature] M.D.
29c. Licansa number: AT2438946
29d. Date signed (Month, Day, Year): FEBRUARY 15, 2001

30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print): Dr. Kristin Roberts, MD
201 E. UNIVERSITY PKWY. BALTIMORE, MD 21218-2895

## State Registrar

31. Data filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: ▶ [signature] G. Sparks

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04565

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ernest Clark

2. Date of Death (Month, Day, Year): February 12 2001

3. Time of Death: 1424

4a. Facility Name *(If not institution, give street and number)*: ST Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 220-03-9234

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sep 23, 1919

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 350 Ballou Court

10f. Zip Code: 21231

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: 42-44

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 5; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Factory

17. Father's Name *(First, Middle, Last)*: William Clark

18. Mother's Name *(First, Middle, Maiden Surname)*: Blanche Marshall

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Bernice Jackson-Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7110 Reno Road Baltimore, MD 21244

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest V.A. Date: Feb 17 2001

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: Calvin L. Williams

22. Name and Address of Facility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Atherosclerotic Cardiovascular Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Emergency Physician

29c. License number: D51853

29d. Date signed *(Month, Day, Year)*: February 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Silverman 900 Caton Avenue Baltimore 21229

**State Registrar**

31. Date Filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature: L. Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Clark, Ernest

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

2177 006 77

Reg. No. 2001 04566

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): PEGGY DELLINGER

2. Data of Death Month: February Day: 08 Yaar: 2001

3. Tima of Death: 12:40 am

4a. Facility Nama (If not institution, give street and number): GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Daath: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: 217-70-0077

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 42 Yrs.

If Undar 1 Yaar: Months: Days:

If Undar 24 Hrs.: Hours: Min.:

8. Data of Birth (Month, Day, Yaar): July 6, 1958

9. Birthplaca (State or Foreign Country): Georgia

Usual Residence of Decedant

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 6000 Bellona Avenue

10f. Zip Coda: 21212

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: black

15. Decedant's Education (Specify only highast grada compliatad)

Elamantary/Secondary (0-12): 9

Collaga (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): disabled

16b. Kind of Business/Industry: none

17. Father's Nama (First, Middle, Last): Frank Moses Sr

18. Mothar's Nama (First, Middle, Maiden Surname): Rosa Paul

19a. Informant's Name/Ralationship (Type, Print): Debra Ashwell/stepmother

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7506 Holabird Ave Baltimore, MD 21222

20a. Method of Disposition: 1☐ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☒ Other (Specify) in state

20b. Placa of Disposition (Name of cemetery, crematory or other place):

Data:

20c. Location - City or Town, Stata:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Nama and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Entar the diseasa, or complications that causad tha death. Do not antar the moda ot dying, such as cardiac or raspiratory arrast, shock, or haart tailure. List only ona causa on aach line.

Approximate Interval Batwaen Onsat and Daath

Immediata Ceuse (Final disaasa or condition rasulting in daath)

a. Sepsis

Dua to (or as a consaquance of):

Sequentially list conditions, if sny, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated avants rasulting in daath) Last

b.

Dua to (or as a consaquance of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: End Stage Renal Disease.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformad? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to complation ot cause of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to madical examinar? 1☐ Yas 2☒ No

26. Placa of Death (Check only one) Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar):

28b. Tima of Injury: M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describa how injury occurrad:

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Cartifiar (Check only one) 1☐ **Certifying Physician**: To the best of my knowledge, daath occurrad at tha time, data and placa, and due to tha causa(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, data and placa, and dua to tha causa(s) and manner stated.

29b. Signatura and title of cartifiar: MD

29c. Licansa number: P13453

29d. Data signed (Month, Day, Yaar): February 08 2001

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): GONZALO GIANELLA MD. 5601 Loch Raven Blvd. Baltimore MD

**State Registrar**

31. Data filed (Month, Day, Yaar): FEB 16 2001

32. Registrar's Signatura: Jennie D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pagas 1 and 2 should be filad within 72 hours aftar daath with the Maryland Department of Health and Mental Hygiena. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after daath.

**To the Funeral Director:** After this cartificata has been signed by the attanding physician and completely filled in by the funaral director, paga 2 should be datachad for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

Amend#1perPHY,#8 perABG793 3/13/2001 EW
Amended Item#30 perDVRG792 2/16/2001 EW

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04567

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ~~JULNEK DONOVAN~~ Donovan Jelnek
2. Date of Death (Month, Day, Year): JANUARY 27, 2001
3. Time of Death: 3:59 AM
4a. Facility Name (If not institution, give street and number): Laurelwood Nursing Home
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

**Funeral Director**

5. Social Security Number: 473-26-9407
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 27, ~~1919~~ 1917
9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 100 Laurel Drive
10f. Zip Code: 21921
10g. Citizen of What Country: USA

11. Marital Status: unk — 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: unk
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): unk; College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk

19a. Informant's Name/Relationship (Type, Print): Laurelwood Nursing Home
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Laurel Drive Elkton, MD 21921

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE RENAL FAILURE — 2 wks.

Due to (or es a consequence of):
b. SEPTICEMIA — 2 wks

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or es a consequence of):
c. BRONCHO PNEUMONIA — 2 wks

Due to (or as a consequence of):
d. ALZHEIMERS OF OLD AGE — 1 month

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jnlmedl. Lyzer
29c. License number: D0074 63
29d. Date signed (Month, Day, Year): 2-1-01

30. Neme end address of person who completed ceuse of death (Item 23e) (Type, Print): Rolando A Najera 118 North ST STE 2A Elkton,Md 21921

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signeture: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04568

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ralph Charles DeAngelis

2. Date of Death: Month January Dey 27, Yeer 2001

3. Time of Death: 9:24 AM

4e. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 080-16-2536

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): March 10,1922

9. Birthplece (State or Foreign Country): NY

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Howard

10c. City, Town or Location: Mt. Airy

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 714 Midway Avenue

10f. Zip Code: 21771

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: 1943 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Upholsterer

16b. Kind of Business/Industry: Upholstery

17. Fether's Neme (First, Middle, Last): Raphael DeAngelis

18. Mother's Name (First, Middle, Maiden Sumame): Repalta Dinanno

19a. Informent's Neme/Reletionship (Type, Print): Robert J. DeAngelis

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6412 Treetop Circle Columbia, Maryland 21045

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): All County Cremation Services, Inc | Dete: 01/30/01

20c. Location - City or Town, Stete: Sykesville, MD

21. Signature of Funerel Service Licensee: ▶ Timothy Harman per DVR

22. Name and Address of Feciility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on eech line. | Approximete Intervel Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth): e. VENTRICULAR FIBRILLATION

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest:

b.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

Atrial Fibrillation

Mitral insufficiency

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpetient 2☑ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture end fille of certifier: ▶ Gary L. Smith M.D. VPMA

29c. License number: D10587

29d. Date signed (Month, Day, Year): 2/15/2001

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): GEORGE L. SMITH, M.D.; VICE-PRES. MED AFFAIRS FREDERICK MEMORIAL HOSP FREDERICK, MD 21701

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 16 2001

32. Registrer's Signeture: ▶ Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

RKD

01-0779-510

DENISE DANDRIDGE

1- For State Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04569

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DENISE D. DANDRIDGE

2. Date of Death (Month, Day, Year): FEBRUARY 10.2001

3. Time of Death: 10:27P. M

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N / A

**Funeral Director**

5. Social Security Number: 213-64-6659

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 45 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 28,1955

9. Birthplace (State or Foreign Country): BALTO. MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: N / A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1509 N. CHAPEL ST.

10f. Zip Code: 21213

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced — X

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRO AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: MD. MEM.PK.

17. Father's Name (First, Middle, Last): WILBERT WARD

18. Mother's Name (First, Middle, Maiden Surname): SHIRLEY CHAMBERS

19a. Informant's Name/Relationship (Type, Print): KEISHA WARD ( DAUGHTER )

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1509 N. CHAPEL ST. BALTO. MD. 21213

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MT. CEM.

Date: FEBRUARY 19,2001

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD. 21213

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnent at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): FEBRUARY 11,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0772-510
B.K.S
LORRAINE EDWARDS

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM# 23,27,& 28a-f per ME 2/11/2001

# Certificate of Death

Reg. No. 2001 04570

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Lorraine M. Edwards | FEB. 10, 2001 | 1722 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 2733 NORTH CALVERT STREET APT.#3 | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-50-2102 | 1☐M 2☒F | 54 Yrs. | | | Jan 31, 1947 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2732 N. Calvert Street | 21218 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondery (0-12) | College (1-4or 5+) | | |
| 12 | | Unknown | Unknown |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Edward Francis Bockstie | Margaret D. Douglas |

| 19a. Informant's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Scott Bockstie /Nephew | 9109 Moonstone Road, Perryhall, MD 21236 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | Feb 14 2001 | Beltsville, MD |

| 21. Signature of Funeral Servica Licansee | 22. Name and Address of Facility |
|---|---|
| Laura C. Hardesty | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC INTOXICATION

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Dete of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probebly 4☒Unknown

| 24e. Was en autopsy performed? | 24b. Were eutopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical exeminer? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined | found 2-10-01 | found 5:22 PM | 1☐Yes 2☒No | unknown |

| 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| found at Residence | 2733 N. Calvert St. apt 3, Balto, MD |

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) end manner as steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | O.C.M.E | FEB. 11, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Dey, Yeer) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 045711

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Loretta Elizabeth Edge

2. Date of Death Month Feb. Day 13, Year 2001

3. Time of Death: 8:42 AM

4a. Facility Name *(If not institution, give street and number)*: Ivy Hall Geriatric Center

4b. City, Town, or Location of Death: Middle River

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-30-4665

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 4, 1907

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5 Brett Court

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Anthony R. Kessler

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary R. Schuster

19a. Informant's Name/Relationship *(Type, Print)*: Loretta E. Blimline-Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 900 F Cedar Crest Court, Edgewood, Maryland 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Mem. Gardens

Date: Feb. 16, 2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: M00694

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D52379

29d. Date signed *(Month, Day, Year)*: 2/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAYITHA SHIVANANDA 1124 Main Avenue Balt MD 21221

**State Registrar**

31. Date Filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04572

Pt. known as George Ford.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GEORGE EDWARD FORD

2. Date of Death — Month: February Dey: 12 Year: 2001

3. Time of Death: 07:25

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 219-18-9143

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar 12, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1701 Eutaw Street #124

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): salesperson

16b. Kind of Business/Industry: variety

17. Father's Name (First, Middle, Last): James Henry Ford Sr

18. Mother's Name (First, Middle, Maiden Surname): Edna R. Buchanan

19a. Informant's Name/Relationship (Type, Print): John Ford/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3018 Mondawmin Avenue Baltimore, MD 21216

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, Md 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Intarvel Batween Onset and Death

Immediate Cause (Finel disease or condition rasulting in daath): a. Urosepsis

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initieted events resulting in deeth) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Urethral Stricture, Hypertension, Chronic Renal Insufficiency Parkinson's disease

23b. Did tobacco uss contribute to the cauus of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residance 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Nelson MD

29c. License number: RES-00000

29d. Date signed (Month, Day, Year): February 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Nelson 2401 West Belvedere Baltimore, MD 21215

**State Registrar**

31. Date filed (Month, Day, Year):

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04573

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: HELEN C. FOLEY

2. Date of Death (Month, Day, Year): FEBRUARY 6 2001

3. Time of Death: 7:40 AM

4a. Facility Name *(If not institution, give street and number)*: FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 038-03-1601

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 3, 1903

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 5009 Frankford Ave

10f. Zip Code: 21206

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: housewife

16b. Kind of Business/Industry: none

17. Father's Name *(First, Middle, Last)*: Thomas Harrow

18. Mother's Name *(First, Middle, Maiden Surname)*: unk

19a. Informant's Name/Relationship *(Type, Print)*: William Wurzberger/nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 922 Tyson Street Baltimore, MD 21201

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* in state

20b. Place of Disposition *(Name of cemetery, crematory or other place)*:

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — 3 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*:

28b. Time of Injury:

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marco A. Zamora MD

29c. License number: D40819

29d. Date signed *(Month, Day, Year)*: FEBRUARY 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARCO ZAMORA MD. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

**State Registrar**

31. Date filed *(Month, Day, Year)*:

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FOLEY, HELEN

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04574

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Leatha Mae Fogg
2. Deta of Death (Month, Dey, Year): Feb. 13, 2001
3. Time of Death: 9:50am
4e. Facility Neme *(If not institution, give street end number)*: Genesis LongGreen Elder Care
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth: NA

**Funeral Director**

5. Social Security Number: 217-22-6956A
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthdey)*: 89 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 05-09-11
9. Birthplace *(Stete or Foreign Country)*: NC

Usual Residence of Decedent

10a. Stete: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4406 Moravia Road Apt.#3
10f. Zip Code: 21206
10g. Citizen of Whet Country?: USA
11. Maritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever In U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest greda complatad)*: Elementery/Secondery (0-12): 9th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Private Duty
16b. Kind of Business/Industry: Nursing
17. Fathar's Name *(First, Middle, Last)*: Isham Moore
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Beatrice Brown
19e. Informant's Name/Reletionship *(Type, Print)*: Josephine C. Hall
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 4406 Moravia Road Apt.#3 Baltimore, MD. 21206
20e. Method of Disposition: 1☒ Buriat 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Crownsville VA Cem.
Dete: 02-20-2001
20c. Location - City or Town, Steta: Crownsville, MD.
21. Signature of Funeral Service Licensee: Emma Morton
22. Neme end Address of Feclity: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

S.S. # 217-28-6956

Leatha Fogg

5

**Physician /Medical Examiner**

23e. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Finel diseese or condition resulting in deeth)
e. Silent myocardial infarction — Minutes

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest
b. Hypertensive cardiovascular Disease — years
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residance 6☐ Othar *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as stated. 2☐ Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: MD
29c. License number: D17118
29d. Date signed *(Month, Dey, Year)*: Feb 13, 2001

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print): Paul Schwartz MD 7700 York Rd 21204

**State Registrar**

31. Dete filed *(Month, Dey, Yeer)*: FEB 16 2001
32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04575

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Julius J. Fowler

2. Date of Death Month Day Year: FERRUARY 13, 2001

3. Time of Death: 2035

4a. Facility Name (If not institution, give street and number): Stella Maris at Mercy

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-34-9883

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): 07/25/1937

9. Birthplece (Stete or Foreign Country): MD

Usuel Residence of Decedent

10a. Stete: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 115 N. Potomac St.

10f. Zip Code: 21224

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1 ☐ Never Merried 2 ☒ Merried 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes: Vietnam

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Service Merager of Vending

16b. Kind of Business/Industry: Blind Industries of MD

17. Fether's Neme (First, Middle, Last): Julius Fowler

18. Mother's Neme (First, Middle, Maiden Surneme): Regina Johnson

19a. Informent's Neme/Reletionship (Type, Print): Mary Fowler/Wife

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 115 N. Potomac St. Baltimore, MD 21224

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Balto-Wash. Crematory

Dete: 02/15/01

20c. Locetion - City or Town, Stete: Laurel, Maryland

21. Signeture of Funeral Service Licensee

22. Neme and Address of Fecility: Moran Ashton Funeral Home, Inc. 3000 Baltimore St. Baltimore, MD 21224

**Physician /Medical Examiner**

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart teilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)

e. Anopia Ensephalopathy

Due to (or es a consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

Alcohol abuse

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Place of Deeth (Check only one): Stella Maris at Mercy

Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Menper of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier: MD

29c. License number: D40854

29d. Dete signed (Month, Dey, Yeer): FEBRUARY 14, 2001

30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore, MD 21202

**State Registrar**

31. Dete filed (Month, Dey, Yeer): FEB 16 2001

32. Registrer's Signeture: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04576

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hazel Rose Flint

2. Date of Death: Month FEB Day 15, Year 2001

3. Time of Death: 12:45pm

4a. Facility Name *(If not institution, give street and number)*: Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 335-34-9457

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 6, 1911

9. Birthplace *(State or Foreign Country)*: Minnesota

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 709 Maiden Choice Lane 217S

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 1

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name *(First, Middle, Last)*: Charles O. Lorimer

18. Mother's Name *(First, Middle, Maiden Surname)*: Helene Unk.

19a. Informant's Name/Relationship *(Type, Print)*: Robert M. Flint/son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 14 Dutton Avenue Catonsville, MD 21228

20a. Method of Disposition: 1☐ Buriat 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Metro Crematory, Inc.

Date: 2/16/01

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause *on* eech fine.

Approximete Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): a. PNEUMONIA — THREE WEEKS

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or es e consequence of):

c. Due fo (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior fo completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Matthew J. Norrett

29c. License number: D44748

29d. Date signed *(Month, Day, Year)*: FEBRUARY 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW J. NORRETT 711 MAIDEN CHOICE LANE CATONSVILLE, MD 21228

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature: Linda D Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04577

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Richard Eugene Godwin Jr.
2. Date of Death (Month, Day, Year): February 16, 2001
3. Time of Death: 5:31 AM
4a. Facility Name (If not institution, give street and number): Gilchrist Center for Hospice Care
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-54-9232
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 11, 1951
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1302 Deanwood RD
10f. Zip Code: 21234
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Ikea
17. Father's Name (First, Middle, Last): Richard Eugene Godwin
18. Mother's Name (First, Middle, Maiden Surname): Ruth Belle Patterson
19a. Informant's Name/Relationship (Type, Print): John Godwin /Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1307 Dalton Rd, Baltimore, MD 21234
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: Feb 19 2001
20c. Location - City or Town, State: Beltsville, MD
21. Signature of Funeral Service Licensee: Laura C. Hardesty
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

**To Be Completed by Funeral Director**

Richard Godwin February 16, 2001 0531A

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung cancer — Due to (or as a consequence of): — 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): February 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04578

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Physician /Medical Examiner** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Marie Sipes Gilbert
2. Date of Death — Month: February Day: 11 Year: 2001
3. Time of Death: 9:50 P.M.
4a. Facility Name (If not institution, give street and number): Future Care Chesapeake
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 220-20-0022
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 26, 1927
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 480 Century Vista DR
10f. Zip Code: 21012
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Underwriter
16b. Kind of Business/Industry: Insurance

17. Father's Name (First, Middle, Last): Raymond Sipes
18. Mother's Name (First, Middle, Maiden Surname): Norma Hess

19a. Informant's Name/Relationship (Type, Print): Sharon A. Martin/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 480 Century Vista DR Arnold, MD 21012

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Glen Haven Memorial Gard
Date: 02/14/01
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

**Physician /Medical Examiner** — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — Due to (or as a consequence of): — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
parkinson disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D-40521
29d. Date signed (Month, Day, Year): February 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR OCHANEY — 325 Hospital Drive Suite 103 Glen Burnie, MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04579

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BEATRICE JEANETTE GHILLANI
2. Date of Death (Month, Day, Year): JAN. 28, 2001
3. Time of Death: 4:14PM
4a. Facility Name (If not institution, give street and number): MANOR CARE
4b. City, Town, or Location of Death: CHEVY CHASE
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 579-58-7440
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 11, 1919
9. Birthplace (State or Foreign Country): CANADA

Usual Residence of Decedent

10a. State:
10b. County:
10c. City, Town or Location: WASHINGTON, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3001 VEAZEY TERRACE N.W.
10f. Zip Code: 20008
10g. Citizen of Whet Country?: CANADA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indien, Bleck, White, etc. Specify: CAUCASIAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 1
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): TRAVEL AGENT
16b. Kind of Business/Industry: FOXHALL AGENCY

17. Father's Neme (First, Middle, Last): JOHN FRANK BELLEFLEUR
18. Mother's Name (First, Middle, Maiden Sumeme): LILLIAN LALONDE

19a. Informent's Neme/Relationship (Type, Print): ELENA GHILLANI Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1401 HAMILTON STREET WASHINGTON, D.C. 20009

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): NATIONAL CREMATORY
Date: 1-30-01
20c. Location - City or Town, State: FALLS CHURCH, VA

21. Signature of Funerel Service Licensee: Diana L. Lewis
22. Name end Address of Facility: AFFORDABLE FUNERAL SERVICE P.O. BOX 542 MERRIFIELD, VA 22116

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line. (Approximete Interval Between Onset end Deeth)

Immediate Cause (Final disease or condition resulting in death): e. CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Due to (or as e consequence of):
b. METHYLCILLAN RESISTANT STAPHLOCOCCAL AUREUS
Due to (or es e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
c. TOBACCO USE DISORDER
Due to (or es e consequence of):
d.

Part It. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: OSTEOPOROSIS WITH VERTEBRAL COMPRESSION FRACTURES

23b. Did tobacco usa contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: Susan Miller MD
29c. License number: D35579
29d. Date signed (Month, Dey, Year): 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN J. MILLER, MD 6844 TULIP HILL TERRACE BETHESDA, MD 20816

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrer's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04580

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| DOROTHY | V. | GOEBEL | FEB | 14 | 2001 | 10:10 AM |

| 4e. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| North Arundel Hospital | Glen Burnie | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 212-26-7075 | 1☐ M 2☒ F | 72 Yrs. | | | | | Jan 27 1929 | Maryland |

Usual Residence of Decedent

| 10e. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Anne Arundel | Glen Burnie | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7900 Bensch Circle | 21060 | USA |

| 11. Meritel Stetus | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Yeer or Detes: | 1☐ Yes 2☒ No *Specify:* | *Specify:* WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 7th | | Homemaker | Household |

| 17. Father's Neme (First, Middle, Last) | 18. Mother's Neme (First, Middle, Meiden Surname) |
|---|---|
| Frank Pugh | Lillian Cullison |

| 19e. Informent's Neme/Relationship (Type, Print) | 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Cheryl Holewinski niece | 420 Shady Lane Pasadena, MD 21122 |

| 20e. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other pleca) | Dete | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify) | Metro Crematory Inc | 2/15/01 | Baltimore, MD |

| 21. Signeture of Funeral Service Licensee | 22. Neme end Address of Feciliby |
|---|---|
| ▶ [signature] | Stallings Funeral Home P.A. 3111 Mountain Road Pasadena, Md 21122 |

**Physician /Medical Examiner**

23e. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List *only one* cause on each line.

| | | Approximete Interval Between Onset and Death |
|---|---|---|
| Immediate Ceuse (Finel diseese or condition resulting in deeth) | e. Acute Myocardial Infarction | 10 minutes |
| | Due to (or es a consequence of): | |
| Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last | b. Ischemic Heart Disease | 2 years |
| | Due to (or es a consequenca of): | |
| | c. Chronic Renal Failure | 6 months |
| | Due to (or es e consequenca of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contributa to the causa of death?** 1☐ Yes 2☑ ~~No~~ 3☐ Probably 4☐ Unknown

| 24e. Wes en eutopsy performed? | 24b. Were eutopsy findings eveileble prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ ~~No~~ | 1☐ Yes 2☐ No |

| 25. Wes case referred to medical exeminer? | 26. Place of Deeth (Check only one) | |
|---|---|---|
| 1☐ Yes 2☐ No | Hospitel: 1☐ Inpatient 2☑ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify) |

| 27. Menner of Deeth | 28e. Dete of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) |

29e. Certifier (Check only one) 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated.

| 29b. Signeture end title of certifier | 29c. License number | 29d. Dete signed (Month, Day, Year) |
|---|---|---|
| ▶ Elliott Gorbaty MD | D20094 | 02/15/01 |

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Elliott Gorbaty MD 7845 Oakwood Rd, Glen Burnie, md, 21061

**State Registrar**

| 31. Dete filed (Month, Day, Year) | 32. Registrer's Signeture |
|---|---|
| FEB 16 2001 | ▶ [signature] |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04581

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BERNICE HAWKINS

2. Date of Death: Month Feb, Day 15, Year 2001

3. Time of Death: 5:00 AM

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 220-18-6272

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 12, 1925

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 736 N. FULTON AVENUE

10f. Zip Code: 21217

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. AFRICAN AMERICAN. Specify:

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DIETARY

16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): SIDNEY MILES

18. Mother's Name (First, Middle, Maiden Surname): ANNIE MILES

19a. Informant's Name/Relationship (Type, Print): LOUISE V. TOYER (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2805 BAKER STREET BALTIMORE, MD 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST VET. CEM.

Date: 2/22/01

20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: WYLIE FUNERAL HOME PA, 638 N. GILMOR STREET BALTIMORE, MD 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Exacerbation of Chronic obstructive Pulmonary disease — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mutombo Kankonde, MD

29c. License number: D46704

29d. Date signed (Month, Day, Year): Feb 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MUTOMBO KANKONDE, ST AGNES HOSPITAL BLT MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME BERNICE HAWKINS

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No 2001 04582

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: RONALD EDWARD HUNSBERGER
2. Date of Death — Month: JANUARY Dey: 31, Yeer: 2001
3. Time of Death: 3:50 AM
4a Facility Name *(If not institution, give street and number)*: 600 W. Railroad Ave #11
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 213-44-0643
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: Jan 4, 1945
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 600 W. Railroad Ave #11
10f. Zip Code: 21804
10g. Citizen of What Country?: USA

11. Marital Status: unk — 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 65-76
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Eduction *(Specify only highest grede completed)*: Elementary/Secondary (0-12): unk — College (1-4or 5+): unk
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unk
16b. Kind of Business/Industry: unk

17. Father's Name *(First, Middle, Last)*: Wilmur G, Hunsberger
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Emma M. Messick

19a. Informant's Name/Relationship *(Type, Print)*: Ronald E. Hunsberger (donor)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 600 W. Railroad Ave #11 Sailsbury, MD 21804

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*
Date
20c. Location - City or Town, Stete

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CA.

Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. SMOKING.
Due to (or as a consequence of):
c. CONGESTIVE HEART
Due to (or as e consequence of):
d. FAILURE.

Perl II. **Other elgnificant conditlone** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco uee contribute to the cauee of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyelcian:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Ronald D Tower
29c. License number: D14256
29d. Date signed *(Month, Day, Year)*: 2/8/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 16 2001
32. Registrar's Signature: Geneva D. Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04583

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: EDDIE L. HARRISON

2. Date of Death — Month: February Day: 6, Year: 2001

3. Time of Death: 645 pm

4a. Facility Name *(If not Institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

**Funeral Director**

5. Social Security Number: 216-42-3308

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 58 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Apr 7, 1942

9. Birthplace *(State or Foreign Country)*: unk

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 501 W. Franklin Street

10f. Zip Code: 21201

10g. Citizen of What Country?: USA

11. Marital Status: unk
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No unk
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Black, White, etc.
*Specify:* black

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): unk
College (1-4or 5+): unk

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unk

16b. Kind of Business/Industry: unk

17. Father's Name *(First, Middle, Last)*: unk

18. Mother's Name *(First, Middle, Maiden Surname)*: unk

19a. Informent's Name/Relationship *(Type, Print)*: Maryland General Hospital

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 827 Linden Ave Baltimore, MD 21201

20e. Method of Disposition
1 [ ] Burial 2 [ ] Cremetion 3 [ ] Removal from State
4 [ ] Donation 5 [X] Other *(Specify)* in state

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*:

Date:

20c. Location - City or Town, Stete:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name end Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**To Be Completed by Funeral Director**

Eddie Lee Harrison

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Multiple Myeloma

Due to (or as a consequence of):
b. Anemia

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c. End Stage Renal Disease

Due to (or as e consequence of):
d. Cheonic Obstructive Pulmonary Disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Wes en eutopsy performed?
1 [ ] Yes 2 [✓] No

24b. Were eutopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?
1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*
Hospitel: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death
1 [✓] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury:

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*:

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*
1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es stated.
2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, In my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: Badika MDO for NAH

29c. License number: P 14571

29d. Date signed *(Month, Day, Year)*: 2/16/01

30. Name and eddress of person who completed cause of deeth (Item 29a) (Type, Print): Ndofunsu Badika, M.D. Fo Maryland General Hospital

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature: Bruce G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04584

George T. Haas 10:45pm

Baltimore, Maryland 21215-0020

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): George T. Haas
2. Date of Death (Month, Day, Year): February 14, 2001
3. Time of Death: 10:45
4a. Facility Name (If not institution, give street and number): 6996 River Drive Road
4b. City, Town, or Location of Death: Edgemere
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-22-4876
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 12, 1927
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Edgemere
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6996 River Drive Road
10f. Zip Code: 21219
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Operations Engineer
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): George L. Haas
18. Mother's Name (First, Middle, Maiden Surname): Frances Supik

19a. Informant's Name/Relationship (Type, Print): Joan Haas /Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6996 River Drive Road, Edgemere, MD 21219

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: Feb 17 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Joann C. Hardesty
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic lung cancer — 15mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard L. Husting
29c. License number: D36814
29d. Date signed (Month, Day, Year): 2/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard L. Husting 7600 Osler Dr. Suite 302 Towson MD

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760,**

45

10+1

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM 8 per fh G796 062601 SS

# Certificate of Death

Reg. No. 2001 01585

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Betty Cassady Hinderer

2. Date of Death: Month February, Day 10, Year 2001

3. Time of Death: 3:35 P.M.

4a. Facility Name (If not institution, give street and number): Harbor Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 180-20--9047

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 14 1926 ~~2001~~

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6612 Kilmarnoch Drive

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lab Technician

16b. Kind of Business/Industry: Westinghouse Research

17. Father's Name (First, Middle, Last): Alston Gordon Cassady

18. Mother's Name (First, Middle, Maiden Surname): Dessie Alice Roby

19a. Informant's Name/Relationship (Type, Print): Gerald Hinderer/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6612 Kilmarnoch Drive Baltimore, MD 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 02/16/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Arteriosclerotic coronary disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lawrence R Gallagher, MD

29c. License number: D01786

29d. Date signed (Month, Day, Year): FEB. 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawrence R. Gallager MD 716 Maiden Choice Lane Balto MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: Lawrence G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04586

**Physician /Medical Examiner**

1. Decedent's Nema *(First, Middle, Last)*: Gertrude H. Hoppert
2. Dete of Death Month / Dey / Year: February 13, 2001
3. Time of Death: 4:00 pm
4e. Facility Neme *(If not institution, give street end number)*: 4809 Althea Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth:

**Funeral Director**

5. Sociel Security Number: 213 36 1321
6. Sex: 1☐ M 2☒ F
7. Aga *(In yrs. lest birthday)*: 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: April 29, 1940
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4809 Althea Avenue
10f. Zip Code: 21206
10g. Citizen of Whet Country?: USA
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk- Supervisor
16b. Kind of Business/Industry: Baltimore County, Md.
17. Fether's Neme *(First, Middle, Last)*: John Hoppert
18. Mother's Nema *(First, Middle, Maiden Sumeme)*: Margaret Sanford
19e. Informent's Neme/Reletionship *(Type, Print)*: Richard Hoppert (Brother)
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 6408 Kenwood Ave. Baltimore, Md. 21237
20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Meadowridge Mem. Park
Date: 2/17/2001
20c. Location - City or Town, Stete: Elkridge, Md.
21. Signature of Funeral Service Licensee: John W. Burkowske — MO1091
22. Nama and Addrass of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

**Physician /Medical Examiner**

23a. Pert. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onsat and Death

Immediate Cause (Final diseasa or condition resulting in deeth): e. Metastatic Gastric Carcinoma — 1 year

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Pert I.

23b. **Did tobacco uae contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Hema 5☒ Rasidance 6☐ Othar *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: Charles Padgett MD

29c. License number: D15546

29d. Date signed *(Month, Dey, Year)*: FEB 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles Padgett MD, 5601 Loch Raven Blvd, Baltimore, MD 21239

**State Registrar**

31. Date filed *(Month, Dey, Year)*: FEB 16 2001

32. Registrer's Signeture: Lawra G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04587

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GEORGE WILLIAM HUDSON
2. Date of Death (Month, Day, Year): FEB 14 2001
3. Time of Death: 09:36AM
4a. Facility Name (If not institution, give street end number): ER UPPER CHESAPEAKE MED CTR
4b. City, Town, or Location of Death: BEL AIR
4c. County of Death: HARFORD

**Funeral Director**

5. Social Security Number: 214-26-6913
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR 2, 1929
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Street
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1129 Boyd Road
10f. Zip Code: 21154
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1953-1955
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Steel Industry
17. Father's Name (First, Middle, Lest): Clarence Hudson
18. Mother's Name (First, Middle, Maiden Surneme): Lula Ruth Maseth
19a. Informant's Name/Relationship (Type, Print): Loretta E. Barrett/Aunt
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 1129 Boyd Road Street, MD 21154
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 2-15-01
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. ASCVD.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: OME
29c. License number: OCME
29d. Date signed (Month, Dey, Year): FEB 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GPNABHMD 728 BELAIR RD BELAIR MD 21014

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04588

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LOREE JOHNSON
2. Date of Death — Month: February Day: 14 Year: 2001
3. Time of Death: 12:30 PM
4a. Facility Name (If not Institution, give street and number): ST. AGNES HEALTHCARE
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: none

**Funeral Director**

5. Social Security Number: 239-58-1355
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 10 1925
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: none
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1521 Race Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Ardy Johnson
18. Mother's Name (First, Middle, Maiden Surname): Mary Gamble Johnson

19a. Informant's Name/Relationship (Type, Print): Emma Glenn - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1521 Race Street Baltimore, Maryland 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 2/17/01
20c. Location - City or Town, State: Lanesboro, Maryland

21. Signature of Funeral Service Licensee: Nancy M. Wallace
22. Name and Address of Facility: Nancy M. Wallace Funeral Service 3405 W. Franklin St. Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. HYPOXIC ENCEPHALOPATHY — DAYS

Due to (or as a consequence of):
b. PNEUMONIA — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: B Bonnie MD
29c. License number: P13595
29d. Date signed (Month, Day, Year): Feb 14 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE BAFFOE-BONNIE ST AGNES HOSPITAL

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LOREE JOHNSON

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

amend item 12 per fh G792 2/16/01 yf

## Certificate of Death

Reg. No. 2001 04589

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: JOHN JACKA
2. Date of Death Month Day Year: Jan. 27, 2001
3. Time of Death: 9:50 PM
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 526-42-5907
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 7, 1938
9. Birthplace *(State or Foreign Country)*: Stockton, CA

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: North Bethesda
10d. Insida City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5440 Marinelli Road #105
10f. Zip Code: 20852
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Urban Planner
16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Paul Jacka
18. Mother's Name *(First, Middle, Maiden Surname)*: Marjorie Young

19a. Informant's Name/Relationship *(Type, Print)*: Jeff Jacka / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10050 E. Zayante Rd., Felton, CA 95018

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [X] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Howard U. Coll. of Med.
Date: 1/31/01
20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: Lori V. Lincoln
22. Name and Address of Facility: Lincoln & Lincoln Funeral Service, 4315 Anacostia Ave., NE Was., DC 20019

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Respiratory failure | 3 days |
| Due to (or as a consequence of): | b. Septic shock | 7 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. pneumonia | 7 days |
| Due to (or as a consequence of): | d. COPD | years |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

CAD
CHF
LE cellulitis.

23b. Did tobacco use contributa to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings availabla prior to completion of ceuse of death? 1 [ ] Yas 2 [ ] No

25. Was cese raferred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturat 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Feldman, M.D
29c. License number: D0046734
29d. Dale signed *(Month, Day, Year)*: 1-31-01.

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): IRENE A. FELDMAN, MD 6000 Executive Blvd #300 Rockville, MD, 20852

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 16 2001
32. Registrar's Signature: B. Sparks

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Jack, John 01-27-01 9:50pm. Montgomery

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04590

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ALEXANDER SCOTT KETCHUM

2. Date of Death (Month, Day, Year): JANUARY 23, 2001

3. Time of Death: 6:20 PM

4e. Facility Name (If not institution, give street and number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 0

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min. 30

8. Date of Birth (Month, Day, Year): Jan. 23, 2001

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1011 E. Wheel Road

10f. Zip Code: 21015

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+): 0

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): None

16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Andrew Scott Ketchum

18. Mother's Name (First, Middle, Maiden Surname): Barbara Alice (Nelson) Ketchum

19e. Informant's Name/Relationship (Type, Print): Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1011 E. Wheel Road, Bel Air, Maryland 21015

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer

Date: 4/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Saint Joseph Medical Center, 7601 Osler Drive, Towson, Maryland 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. EXTREME PREMATURITY

Due to (or as a consequence of): PRETERM LABOR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of): TWIN GESTATION

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Z. A. Sinnar

29c. License number: D 20025

29d. Date signed (Month, Day, Year): 1-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ZEHRA SINNAR, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: Barbara G Sparks

ORIGINAL

DHMH 16 Rev 6/95

K.B.

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04591

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William, K, KOONTZ
2. Date of Death: Month February Day 13 Year 2001
3. Time of Death: 5:55 AM
4a. Facility Name (If not institution, give street and number): Saint Agnes Hospital 900 Caton Avenue
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 213-09-6043
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 18, 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3850 Old Columbia Pike
10f. Zip Code: 21043
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: 1941 - 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): General Contract Worker
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Leslie Koontz
18. Mother's Name (First, Middle, Maiden Surname): Estelle Sisk

19a. Informant's Name/Relationship (Type, Print): Ms. Mary E. Koontz
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3850 Old Columbia Pike Ellicott City, Maryland 21043

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park, Inc.
Date: 02/15/01
20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: [signature] M0053
22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Bradyarrhythmia — minutes

Due to (or as a consequence of):
b. Congestive Heart Failure — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. End Stage Renal Disease — years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease
Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Shawn Bethell MD
29c. License number: P-12599
29d. Date signed (Month, Day, Year): February 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shawn Bethell MD 900 Caton Avenue Baltimore, Maryland

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

William K. Koontz

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04592

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Andrew Lioi

2. Date of Death (Month, Day, Year): February 13, 2001

3. Time of Death: 10:45 PM

4a. Facility Name (If not institution, give street and number): St. Agnes Nursing & Rehab Center

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 212-05-7693

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 96 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 7, 1905

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Woodmoor

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3204 Mayfair Road

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 5

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel Worker

16b. Kind of Business/Industry: Armco Steel

17. Father's Name (First, Middle, Last): Francesco Lioi

18. Mothar's Name (First, Middle, Maiden Surname): Maria A. Pirosa

19a. Informant's Name/Relationship (Type, Print): Marie Barron Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9707 Riverside Circle; Ellicott City, Maryland 21042

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Cemetery

Date: 2/17/01

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: Joseph J. Kelleher MD1333

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that causad tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Stroke — One week.

Due to (or as a consequence of):

b. Hypertension — Years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investagation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as steted.

2 ☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N B Vellanki

29c. License number: D 30469.

29d. Date signed (Month, Day, Year): February 14 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N B Vellanki, MD; 9055 Chevrolet Drive, #100, Ellicott City, MD 21042.

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrer's Signature: Jennifer L. Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04593

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOSEPH LANGLEY
2. Date of Death: Month 2 Day 6 Year 01
3. Time of Death: 11 PM
4a. Facility Name (If not institution, give street and number): Genesis Multi Medical
4b. City, Town, or Location of Death: Towson
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 212-10-1142
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 2, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7700 York Road
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): carpenter
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): John Morgan Langley
18. Mother's Name (First, Middle, Maiden Surname): Jennie McDonough

19a. Informant's Name/Relationship (Type, Print): Imelda Langley/spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7700 York Rd Towson, MD 21204

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Senile Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD Asking
29c. License number: D17118
29d. Date signed (Month, Day, Year): Feb 7, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwarz MD 7700 York Rd 21204

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: Geneva G Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

01-0823-510
mnmr
Mary Ruth Lutz

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04594

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Ruth Lutz
2. Date of Death (Month, Day, Year): February 13, 2001
3. Time of Death: 1415 pM
4a. Facility Name (If not institution, give street and number): 3310 Benson Avenue, Apartment #215
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 220-05-8414
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/08/1917
9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Arbutus
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 3310 Benson Ave, Apt. 215
10f. Zip Code: 21227
10g. Citizen of Whet Country?: USA
11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accounting Department
16b. Kind of Business/Industry: Baltimore Sales Book
17. Father's Name (First, Middle, Last): Charles L. Cooper
18. Mother's Name (First, Middle, Meiden Surneme): Lyda E. Howard
19a. Informant's Name/Relationship (Type, Print): Brenda Coyne
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2200 Tall Pines Ct. Baltimore, MD 21228
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Poplar Grove Cemetery
Dete: 02/17/02
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: ▶ Robert J. Bodack, Jr.
22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or es a consequence of):
c. Due to (or as e consequence of):
d. Due to (or as e consequence of):

IF FEMALE:
23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☒Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown
23d. Dete of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given In Part I.

23e. Did tobecco use contribute to the cause of deeth? 1☐Yes 2☐No 3☐Probebly 4☒Unknown
24a. Was en autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Deeth (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. M. Titus
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jack M. Titus, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signeture: ▶ Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04595

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lola F. Layne
2. Data of Daath — Month: FEB Day: 14, Yaar: 2001
3. Tima of Death: 4:30 AM
4a Facility Nama (If not institution, giva street and number): Riverview Care Center
4b. City, Town, or Location of Daath: Essex
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 406-16-7366
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 81 Yrs. — If Under 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): AUG 7, 1919
9. Birthplaca (Stata or Foraign Country): KY

Usual Rasidance of Decedant

10a. Stata: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 1 Eastern Blvd
10f. Zip Coda: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowad 4☐ Divorcad
12. Was Decadant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Give Yaar or Datas:
13. Was Decadent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decadent's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad): Waitress
16b. Kind of Businass/Industry: Food

17. Fathar's Nama (First, Middla, Last): David C. Fuller
18. Mothar's Nama (First, Middla, Maidan Surnama): Effie McGlothin

19a. Informant's Name/Relationship (Type, Print): Rosemary Diamond/Daughter
19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda): 8028 Del Haven, Baltimore, MD 21222

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar placa): Ashland Cemetery
Data: 2/19/01
20c. Location - City or Town, Stata: Ashland, KY

21. Signatura of Funaral Sarvica Licensaa: Daniel Simons
22. Nama and Addrass of Facility: Miller Funeral Home 1941 Carter Ave. Ashland, KY 44101

**Physician /Medical Examiner**

23a. Part I. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on each line.

Approximate Intarval Batwaen Onsat and Daath

Immediata Causa (Final disaasa or condition rasulting in death)
a. Cardiac Arrhythmias — 2-3 hrs
Due to (or as a consaquance of):
b. Acute Renal Failure — one week

Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated avants rasulting in death) Last
Dua to (or as a consaquence of):
c.
Due to (or as a consaquence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.
Severe Anemia, Ischemic Cardiomyopathy

23b. Did tobacco uae contributa to the cauae of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad? 1☐ Yes 2☒ No
24b. Ware autopsy findings availabla prior to completion of causa of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No
26. Placa of Death (Chack only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Residance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Straat and Numbar or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar statad.

29b. Signatura and titla of certifiar: M.D
29c. Licansa number: D-38754
29d. Data signad (Month, Day, Yaar): 02-14-2001.

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Type, Print): MALIKA WASSEM. 709. EASTERN BLVD. MD - 21221.

**State Registrar**

31. Data filed (Month, Day, Yaar): FEB 16 2001
32. Registrar's Signatura:

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04596

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: **Virginia Charlotte von Lossberg**
2. Date of Death Month Day Year: Feb 13, 2001
3. Time of Death: 8:05 pm
4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-66-4965
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr 4, 1915
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9122 Northfield Rd.
10f. Zip Code: 21042
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Dr. Peter Joseph Pipitone
18. Mother's Name *(First, Middle, Maiden Surname)*: Charlotte Frederick

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Lewis vonLossberg
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Rt. 1, Box 214 Rivesville, West Virginia 26588

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crest Lawn Memorial Gardens
Date: 02/16/01
20c. Location - City or Town, State: Marriottsville, Maryland

21. Signature of Funeral Service Licensee: [signature] M00535
22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D054636
29d. Date signed *(Month, Day, Year)*: Feb 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Syed Hague 201-109 Back River Neck Rd. Baltimore, MD 21221

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No 2001 04597

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: HELEN R. LORENZ
2. Date of Death Month: FEB Day: 12 Year: 2001
3. Time of Death: 1245 pm
4a. Facility Name *(If not institution, give street and number)*: HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

**Funeral Director**

5. Social Security Number: 216-05-4852
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct 24, 1908
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard County
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7530 Sanner Road
10f. Zip Code: 20723
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name *(First, Middle, Last)*: George H. Wendler
18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine Unknown
19a. Informant's Name/Relationship *(Type, Print)*: Mr. John Edward Lorenz
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7530 Sanner Road Laurel, Maryland 20723
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: All County Cremation Services, Inc.
Date: 02/15/01
20c. Location - City or Town, State: Sykesville, Maryland
21. Signature of Funeral Service Licensee: John S. Hall Mollis
22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in death)
a. PNEUMONIA
Due to (or es e consequence of):
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted evants resulting in death) Lest
b.
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.: ARTERIAL OCCLUSIVE DISEASE ISCHEMIC RIGHT FOOT

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and plece, end due to the cause(s) and menner steted.
29b. Signature end title of certifier: Chudian MD
29c. License number: D42892.
29d. Date signed *(Month, Dey, Year)*: FEB 12 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): FRANCIS CHUDIAN 10724 LITTLE PATUXENT PARKWAY COLUMBIA MD 21044

**State Registrar**

31. Dete filed *(Month, Dey, Year)*: FEB 16 2001
32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04598

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Henry Moss

2. Date of Death (Month, Day, Year): February 13 2001

3. Time of Death: 4:20 AM

4a. Facility Name (If not institution, give street and number): University of Maryland Medical System

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 220-18-4630

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4-26-28

9. Birthplace (State or Foreign Country): OXFORD N.C.

Usual Residence of Decedent

10a. State: Md

10b. County:

10c. City, Town or Location: BALTO.

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1217 W. Fayette

10f. Zip Code: 21223

10g. Citizen of What Country: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER

16b. Kind of Business/Industry: Steel Mill

17. Father's Name (First, Middle, Last): HENRY MOSS

18. Mother's Name (First, Middle, Maiden Surname): AMANDA YANCY

19a. Informant's Name/Relationship (Type, Print): MARY BOONE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 413 N. PATTERSON PARK BALTO MD

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST | Date: 2-20-01

20c. Location - City or Town, State: Reisterstown MD

21. Signature of Funeral Service Licensee: Wesley Chavis Jr.

22. Name and Address of Facility: CHAVIS F.H. 2007 EASTERN AVE BALTO. Md-21231

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Subdural hematoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Brain herniation

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD-PhD

29c. License number: P14640

29d. Date signed (Month, Day, Year): February 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Chang MD 22 South Greene St, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

amend item 20b per fh G792 2/16/01 vf
AMENDED ITEM #12per FH G792 022001 SS

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04599

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Donald Edward McAvoy
2. Date of Death (Month, Day, Year): February 13, 2001
3. Time of Death: 7:00 AM
4a. Facility Name (If not institution, give street and number): 8005 Douglas Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-26-4998
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): May 10, 1931
9. Birthplece (State or Foraign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8005 Douglas Avenue
10f. Zip Coda: 21244
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [X] No If Yes, Give Year or Dates: 3/13/51-5/18/52
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Americen Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Route Salesman
16b. Kind of Business/Industry: Bakery
17. Father's Neme (First, Middle, Last): Joseph McAvoy
18. Mother's Name (First, Middle, Meiden Surneme): unk
19a. Informant's Name/Relationship (Type, Print): Anna M. McAvoy Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 8005 Douglas Avenue; Baltimore, Maryland 21244
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Baltimore Washington Crematory
Date: 2/14/01
20c. Location - City or Town, State: Laurel, Maryland
21. Signature of Funeral Service Licensee
22. Name and Address of Feclility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. CONGESTIVE HEART FAILURE — 6 mos
Due to (or es e consequence of):
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Lest:
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part ii. **Other elgnificent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

ATRIAL FIBRILLATION

STROKE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medicat examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streat, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier:
29c. License number: D36373
29d. Date signad (Month, Day, Year): 2/13/01

30. Name and eddress of person who completed causa of death (Item 23e) (Type, Print): MARTIN B ALBORNOZ

**State Registrar**

31. Date filed (Month, Dey, Yeer): FEB 16 2001
32. Registrar's Signature: Lenora D. Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No: 2001 01600

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Rita L. Maurer

2. Date of Death — Month: February Day: 15, Year: 2001

3. Time of Death: 3:30 am

4a. Facility Name *(If not institution, give street and number)*: Heritage Nursing Center

4b. City, Town, or Location of Death: Dundalk

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212 18 5533

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 12, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 105 Brett Court

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles Laird

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Cavanaugh

19a. Informant's Name/Relationship *(Type, Print)*: Alva Simpkins (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1133 Brodbeck Rd. Hampstead, Md. 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Mem. Gardens — Date: 2/17/2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: John W. Burkowske — MO1091

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c. ATRIAL FIBRILLATION

Due to (or as a consequence of):

d. DIABETES MELLITUS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Savinder Julka MD

29c. License number: D27188

29d. Date signed *(Month, Day, Year)*: February 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Savinder Julka MD 2 Market Place Baltimore, Md. 21222

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature: D. Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04601

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Dale Maufre

2. Date of Death — Month: February Day: 14 Year: 2001

3. Time of Death: 10:15PM

4e. Facility Name (If not institution, give street and number): Genesis Eldercare Loch Raven Center

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212-36-4797

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11-16-1938

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Rosedale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7505 Tomahawk Court Apt. A

10f. Zip Code: 21237

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Collector

16b. Kind of Business/Industry: Metris Corporation

17. Father's Name (First, Middle, Last): Joseph Cimino

18. Mother's Name (First, Middle, Maiden Surname): Margaret Miller

19a. Informant's Name/Relationship (Type, Print): Donna Van Sant/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111519 Notchcliff Road Glen Arm, MD 21057

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 2/16/01

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21237

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Terminal small cell cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martha C. Raymundo MD

29c. License number: D54518

29d. Date signed (Month, Day, Year): 2/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARTHA C. RAYMUNDO 3007 E. Northern Parkway Baltimore MD 21214

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04602

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William M. May, Jr.

2. Date of Death (Month, Day, Year): February 15, 2001

3. Time of Death: 9:30 AM

4a. Facility Name (If not institution, give street and number): 906 Mace Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-36-8232

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 20, 1939

9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Whiteford

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3868 Peach Orchard Road

10f. Zip Code: 21160

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk/Carpenter

16b. Kind of Business/Industry: Grocery Store/ Construction

17. Father's Name (First, Middle, Last): William M. May, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Gertrude Wockenfuss

19a. Informant's Name/Relationship (Type, Print): Bonnie G. May/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3868 Peach Orchard Road Whiteford, MD 21160

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Metro Crematory Inc.

Date: 2-16-01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Non Hodgkin's Lymphoma — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Daughter's Residence

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Celano, MD

29c. License number: D30929

29d. Date signed (Month, Day, Year): February 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL Celano, MD 6565 N. Charles ST BALTIMORE MD 21204

**State Registrar**

31. Date Filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04603

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Chukwuma Nwachinemere

2. Date of Death Month: January Day: 3 Year: 2001

3. Time of Death: 09:32 Am

4a. Facility Name (If not institution, give street end number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

**Funeral Director**

5. Social Security Number: N/A

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday) Yrs.: If Under 1 Year Months: Days: If Under 24 Hrs. Hours: Min.: 47

8. Date of Birth (Month, Day, Year): 1-3-2001

9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: middle River

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street end Number: 8 Bellanco Court

10f. Zip Code: 21220

10g. Citizen of What Country? USA

11. Meritel Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Raca - American Indien, Bteck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): N/A College,(1-4or 5+): N/A

16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Father's Neme (First, Middle, Last): Markswell Nwachinemere

18. Mother's Name (First, Middle, Maiden Surneme): Chienyenwa Nwachinemere

19e. Informent's Name/Relationship (Type, Print): Chienyenwa Nwachinemere/mother

19b. Meiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 8 Bellanco Ct- Middle River, Md 21220

20e. Methop of Disposition: 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removat from State 4 ☐ Donation 5 ☒ Other (Specify) Dispasal

20b. Place of Disposition (Name of cemetery, cremetory or other place): Johns Hopkins Hospital Date: 1/4/01

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeret Service Licansee: Deborah Evans

22. Name end Address of Fecility: JHH-600 N. Wolfe St. 21287

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. Ltst *only one* cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

e. extreem prematurity — Due to (or as e consequenca of):

Sequentiatly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

b. preterm delivery — Due to (or as e consequenca of): — 47 minutes

c. — Due to (or es a consequenca of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: None

23b. **Did tobacco uss contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveitable prior to completion of cause of deeth? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Deeth (Check only one) Hospitel: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) end menner es stated. 2 ☐ **Medical Examiner:** On the basis of exemnetion and/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: MD

29c. License number: D23612

29d. Dete signed (Month, Dey, Year): 1/03/01

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print): Fwriter, Johns Hopkins Hospital 600 N Wolfe St. Baltimore

**State Registrar**

31. Dete filed (Month, Dey, Year): FEB 16 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The iew requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

K.B

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04604

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Alice Parker
2. Date of Death: Month 02 Day 12 Year 2001
3. Time of Death: 4:07 PM
4a. Facility Name (If not institution, give street end number): The Wesley Home, Inc.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-07-6578
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 27, 1901
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street end Number: Wesley Home, Inc. 2211 W. Rogers Ave.
10f. Zip Code: 21209
10g. Citizen of What Country: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembler
16b. Kind of Business/Industry: Western Electric

17. Fether's Neme (First, Middle, Last): George Henry Meyers
18. Mother's Name (First, Middle, Maiden Surneme): Rose Redmon

19a. Informent's Neme/Reletionship (Type, Print): Ernest P. Peterson
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 8218 Oakleigh Road Baltimore, MD 21234

20a. Method of Disposition: ☒ 1☐ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Poplar Grove Cemetery
Date: 2/16/01
20c. Location - City or Town, State: Cockeysville, Maryland

21. Signeture of Funeral Service Licensee: Tracy H. Carpenter
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimoe, Maryland 21211

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in death):
a. ACUTE RESPIRATORY FAILURE

Due to (or es e consequence of):
b. Cerebrovascular Accident

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of):
c. Hypertensive Cerebrovascular Disease

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia - Multi Infarct Type

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemineticn end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: Robert E. Roby M.D.
29c. License number: D-19425
29d. Date signed (Month, Day, Year): 12/13/01

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): ROBERT E. ROBY, M.D. - 2211 W. ROGERS AVE BALTO, MD 21209

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrer's Signeture: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

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Parker, Mary
Baltimore, Maryland 21215-0020

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet tha death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificata has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 04605

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Data of Death Month Day Year | 3. Tima of Death |
|---|---|---|
| LYNDA Ruth PACKECH | FEBRUARY 05 2001 | 1603 M |

| 4a. Facility Nama (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 809 CYPRESS BEACH ROAD | ARNOLD | ANNE ARUNDEL CO. |

**Funeral Director**

| 5. Social Security Numbar | 6. Sex | 7. Aga (In yrs. last birthday) | If Under 1 Year Months / Days | If Under 24 Hrs. Hours / Min. | 8. Data of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-60-2470 | 1☐ M 2☒ F | 48 Yrs. | | | May 31, 1952 | Washington |

Usual Residance of Decedent

| 10a. Stata | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Arnold | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Coda | 10g. Citizan of What Country? |
|---|---|---|
| 809 Cypress Beach Road | 21012 | USA |

| 11. Marital Status | 12. Was Decedant Evar in U.S. Armed Forces? | 13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) | 14. Raca - Amarican Indian, Black, Whita, atc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Giva Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedant's Educetion (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Businass/Industry |
|---|---|---|---|
| Elemantary/Secondary (0-12) | Collega (1-4or 5+) | | |
| 12 | 0 | floral designer | florist |

| 17. Father's Name (First, Middle, Last) | 18. Mothar's Nama (First, Middle, Maiden Surname) |
|---|---|
| Nicholas Packech | Mildred Chronister |

| 19a. Informant's Name/Ralationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Josie Anello/friend | 809 Cypress Beach Rd Arnold, MD 21012 |

| 20a. Method of Disposition | 20b. Placa of Disposition (Name of cemetery, crematory or other place) | Data | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☒ Other (Specify) in state | | | |

| 21. Signatura of Funeral Service Licensee | 22. Nama and Addrass of Facility |
|---|---|
| Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that ceused tha daath. Do not antar the moda of dying, such as cerdiac or raspiratory arrast, shock, or haart failura. List only ona ceusa on each line.

Approximate Intarval Batween Onset and Death

Immediate Cause (Final disaase or condition rasulting in daath)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Entar Undarlying Cause (Disaasa or injury that initiated events rasulting in daath) Last

b. HIV

Dua to (or as a consequance of):

c.

Dua to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in tha past 12 months? | 23c. If yas, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yas 2☐ No 9☒ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

Cholangiocarcinoma

23e. Did tobecco use contribute to tha cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Wara autopsy findings availabla prior to completion of causa of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was cesa rafarred to madical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yas 2☐ No | Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☒ Rasidanca 6☐ Other (Specify) |

| 27. Manner of Daath | 28a. Data of Injury (Month, Day Yaar) | 28b. Tima of Injury | 28c. Injury at Work? | 28d. Dascriba how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not ba datarmined | | M | 1☐ Yas 2☐ No | |

| 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, date and place, and dua to tha cause(s) and manner as stated.

2☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at the tima, data and placa, and dua to tha causa(s) and mannar statad.

| 29b. Signatura and titla of cartifiar | 29c. Licensa numbar | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| William P. Jones Deputy MO | D06054 | 2/6/01 |

30. Nama and address of person who complatad causa of death (Itam 23a) (Typa, Print)

William P. Jones, MO 695 America 21035

| 31. Data filed (Month, Bay, Year) | 32. Registrar's Signatura |
|---|---|
| FEB 16 2001 | Jennie G Sparks |

**State Registrar**

DHMH 17 Rav 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04606

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GLENN M. PLUNKETT

2. Date of Death: Month: February Day: 8 Year: 2001

3. Time of Death: 7:26 PM

4a. Facility Name (If not institution, give street and number): University of Maryland Medical Systems

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 248-44-2225

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months: Days:

If Under 24 Hrs.: Hours: Min.:

8. Date of Birth (Month, Day, Year): Apr 10, 1919

9. Birthplace (State or Foreign Country): Mississippi

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 317 Whitfield Road

10f. Zip Code: 21228

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: '41-47

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): +5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): branch manager

16b. Kind of Business/Industry: government

17. Father's Name (First, Middle, Last): Thomas Plunkett

18. Mother's Name (First, Middle, Maiden Surname): Erie Mcabee

19a. Informant's Name/Relationship (Type, Print): Ethel Plunkett/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 317 Whitfield Road Baltimore, MD 21228

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Lung Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P13997

29d. Date signed (Month, Day, Year): February 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MD TAYLOR 22 South Greene St., Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: Irene G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04607

Peterson, John

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John Daniel Peterson
2. Date of Death (Month, Day, Year): February 15, 2001
3. Time of Death: 2:30A.M
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 208 05 4232
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 7, 1913
9. Birthplace (State or Foreign Country): Pennsylvania

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 28 Crafton Rd.
10f. Zip Code: 21221
10g. Citizen of What Country?: USA
11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Aerospace
17. Father's Name (First, Middle, Last): Elmer B. Peterson
18. Mother's Name (First, Middle, Maiden Surname): Lulu Kellar
19a. Informant's Name/Relationship (Type, Print): Nancy Jean Eicks (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28 Crafton Rd. Baltimore, Md. 21221
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens Of Faith Cemetery
Date: 2/17/2001
20c. Location - City or Town, State: Baltimore, Md.
21. Signature of Funeral Service Licensee: John W. Burkowske MO1091
22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers', Cerebrovascular Accident, Parkinson's Disease

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D47390
29d. Date signed (Month, Day, Year): FEBRUARY 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Ivan Borrello 9000 Franklin Square Drive Baltimore, MD 21237

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04608

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: **Jacqueline M. Pursley**

2. Date of Death Month / Day / Year: Feb 13, 2001

3. Time of Death: 3:00 p.m.

4a. Facility Name *(If not institution, give street and number)*: 6280 Blue Dart Place

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 050-32-3742

6. Sex: 1☐ M 2☐ F

7. Age *(In yrs. last birthday)*: 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar 17, 1940

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street and Number: 6280 Blue Dart Place

10f. Zip Code: 21045

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Robert Crittsinger

18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Halas

19a. Informent's Name/Reletionship *(Type, Print)*: Mr. Jesse Pursley

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6280 Blue Dart Place Columbia, Maryland 21045

20a. Method of Disposition: 1☐ Buriel 2☐ Cremetion 3☒ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Forest Lawn Crematory

Date: 02/16/01

20c. Location - City or Town, Stete: Buffalo, New York

21. Signature of Funeral Service Licensee: M00535

22. Name and Address of Facility: Fretthold Funeral Home, Inc. 1241 Oliver Street North Tonawanda, New York 14120

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in deeth)

a. Metastatic Breast Cancer to Liver — 4-5years

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

b. Due to (or as e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier: Nicholas Koutrelakos MD

29c. License number: D38509

29d. Date signed *(Month, Day, Year)*: February 14 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Koutrelakos, Nicholas MD Two Knoll North Drive Columbia, MD 21045

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that tha death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04609

GEORGE REES, FEBRUARY 7, 2001
Baltimore, Maryland 21215-0036 @ 1:50AM

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GEORGE T. REES
2. Date of Death: Month FEBRUARY Day 7 Year 2001
3. Time of Death: 1:15 AM
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 324-26-9788
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 16, 1932
9. Birthplace (State or Foreign Country): Illinois

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 111 West Road
10f. Zip Code: 21204
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): +5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): training specialist
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): George Rees
18. Mother's Name (First, Middle, Maiden Surname): Alma Durham

19a. Informent's Name/Relationship (Type, Print): Mary Anne Rees/spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 West Road Towson, MD 21204

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): e. end Stage renal disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last:
b.
Due to (or as e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cirrhosis of Liver

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): February 7, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

**State Registrar**

31. Date filed (Month, Day, Year): MAR 2 8 2001
32. Registrer's Signeture: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

amend item 1 per md G792 2/16/01 yf

# Certificate of Death

Reg. No. 2001 04610

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HORACE J. ROLLINS

2. Date of Death — Month: FEBRUARY Dey: 13 Year: 01

3. Time of Death: 4:37 PM

4e. Facility Name (If not institution, give street and number): Northwest Hospital

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-28-2830

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9-3-1932

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Woodlawn

10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10e. Street and Number: 2600 Essex Rd. APT 101

10f. Zip Code: 21207

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Raca - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th Grade | College (1-4or 5+)

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Chipper

16b. Kind of Business/Industry: Bethlehem Steel

17. Fether's Neme (First, Middle, Last): Horace Rollins

18. Mother's Neme (First, Middle, Maiden Surneme): Isabella Griffin

19e. Informent's Neme/Reletionship (Type, Print): Anne y Rollins | Wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2600 Essex Rd. Baltimore, MD. 21207

20a. Method of Disposition: 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Arbutus Cemetery

Dete: 2/19/01

20c. Location - City or Town, State

21. Signeture of Funeral Service Licensee: Vaughn C Greene

22. Name and Address of Facility: Vaughn C Greene Funeral Service 5151 Balto. Nat'l Pike Balto. MD. 21229

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in death)

e. METASTATIC LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Plece of Deeth (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Deeth: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) end manner es steted. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated.

29b. Signeture and title of certifier: K. S. RAO M.D.

29c. License number: D 43462

29d. Date signed (Month, Dey, Year): FEBRUARY 13, 01

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): K. S. RAO. M. D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 16 2001

32. Registrer's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the deeth certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No: 2001 04611

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| HUGH | REYNOLDS | | FEBRUARY 10 2001 | 8:30 AM |
| 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or Location of Death | | 4c. County of Death |
| JOHNS HOPKINS BAYVIEW MEDICAL CENTER | | BALTIMORE | | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577-40-5782 | 1☒M 2☐F | 69 Yrs. | | | Oct 15, 1931 | unk |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Baltimore | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1046 Old Northpoint Road | 21222 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | unk 1☐Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | unk | unk |
| unk | unk | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| unk | Dorothy Altemus |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Brian Zapp/attorney | unk |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) in state | | | |

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | SEPSIS | 48 HOURS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): b. | URINARY TRACT INFECTION | 2 WEEKS |
| Due to (or as a consequence of): c. | CORONARY ARTERY DISEASE | 24 HOURS |
| Due to (or as a consequence of): d. | | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES, HYPERCHOLESTEROLEMIA, DEMENTIA, PEPTIC ULCER DISEASE

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐Yes 2☐No 3☐Probably 4☒Unknown | 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| OLNES | D0056497 | FEBRUARY 12, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW OLNES MD 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | Jenna D. Sparks |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04612

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Bertha V. Reynolds
2. Date of Death Month / Day / Year: February 9 2001
3. Time of Death: 9:30 A.M.
4a. Facility Name *(If not institution, give street and number)*: St. Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 074-16-0392
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 19 1906
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4300 Belvieu Ave
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): (Unknown) / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeper
16b. Kind of Business/Industry: (Unknown)

17. Father's Name *(First, Middle, Last)*: Samuel Reynolds
18. Mother's Name *(First, Middle, Maiden Surneme)*: Bertha Neath

19a. Informant's Name/Relationship *(Type, Print)*: Catherine Peckins/Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 61-25 98th Street Apt. 16E Rego Park, NY 11374

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Balto-Wash. Crematory
Date: 02/12/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Neme and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faiture. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)
a. pancreas mass — 3wks
Due to (or as a consequence of):
b. Congestive heart failure — 1 month
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings availeble prior to completion of ceuse of death? 1☐ Yes 2☑ No

25. Was cese referred to medicat examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ Mich-D Kitoup, MD
29c. License number: D31865
29d. Date signed *(Month, Day, Year)*: 2/12/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Rm 206 821 N. Gutaw street, Baltimore, md 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Bertha Reynolds

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

amend item 20b per fh 6792 2/16/01 yf

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04613

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Jean B. Starling

2. Date of Death Month: Feb. Day: 11 Year: 2001

3. Time of Death: 4:30 PM

4a. Facility Name *(If not institution, give street and number)*: St. Joseph's Hospital

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212-50-1358

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 22 1915

9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1414 Front Ave.

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Friedrich Carl Bruckmann

18. Mother's Name *(First, Middle, Maiden Surname)*: Myrtle Vivian Holton

19a. Informant's Name/Relationship *(Type, Print)*: Deborah S. Dowell/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 112 Belmore Rd., Lutherville, MD 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Balto. Wash. Crematory Date: 2/15/01 ~~2/14/01~~

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: Lowell M. Lemmon

22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — Days

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or as e consequence of):

d. Due to (or as e consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel deeth 3☐ Ectopic pregnency 4☐ Pregnent at time of deeth 5☐ Other *(specify)* 9☐ Unknown

23d. Dete of delivery Month Day Year

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

Osteoporosis

23e. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy tindings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: 037362

29d. Date signed *(Month, Day, Year)*: 2/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anthony Serafis, M.D. 1205 York Rd., Suite 32C, Lutherville, MD 21093

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature: G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04614

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: David Schoming

2. Date of Death Month / Day / Year: February 12, 2001

3. Time of Death: 1:00 pm

4a. Facility Name *(If not institution, give street and number)*: rederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 196-20-9277

6. Sex: X 1☐ M 2☐ F

7. Age *(In yrs. last birthday)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 31, 1931

9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. Stete: MD

10b. County: Carroll

10c. City, Town or Location: Mt. Airy

10d. Inside City Limits: X 1☐ Yes 2☐ No

10e. Street and Number: 7830 East Hill Drive

10f. Zip Code: 21771

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed X 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? X 1☐ Yes 2☐ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) X 1☐ Yes 2☐ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Music Teacher

16b. Kind of Business/Industry: Self-employed

17. Father's Name *(First, Middle, Last)*: George Francis Schoming

18. Mother's Name *(First, Middle, Meiden Surname)*: Lorna Luella Washabaugh

19a. Informant's Name/Relationship *(Type, Print)*: Geoffrey Schoming /Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4431 Hayfield Drive, Manchester, MD 21102

20a. Method of Disposition: X 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory | Date: Feb 14 2001

20c. Location - City or Town, Stete: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ [signature] M009880

22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): e. Metastatic Bladder Cancer — months

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last:

b. Due to (or es a consequenca of):

c. Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD

23b. Did tobacco use contribute to the cauee of death? 1☑ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requiras that the death certificata be executed within 24 hours after daath.
To the Funeral Director: Aftar this certificata has been signed by the attending physician and completely filled in by the funaral director, paga 2 should be detached for use as tha burial-transit

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D26516

29d. Date signed *(Month, Day, Year)*: FEB 13 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen J. Galson MD 1475 TANEY Ave FRED MD 21702

10

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature: ▶ [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04615

George Alton Stokes
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: George Alton Stokes
2. Data of Daath — Month: Febuary; Dey: 10; Yaar: 2001
3. Tima of Deeth: 5:50 AM
4a. Facility Name *(If not institution, give straat and number)*: Manokin Manor
4b. City, Town, or Location of Deeth: Princess Anne
4c. County of Deeth: Somerset

**Funeral Director**

5. Social Sacurity Number: 220-12-1187
6. Sax: 1☒ M 2☐ F
7. Aga *(In yrs. last birthday)*: 82 Yrs.
If Under 1 Yaar — Months: ; Days:
If Undar 24 Hrs. — Hours: ; Min.:
8. Data of Birth *(Month, Day, Yaar)*: Sept. 29, 1918
9. Birthplaca *(Stata or Foraign Country)*: Maryland

Usual Rasidance of Decedant

10a. Stafe: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 402 Kent Road N.E.
10f. Zip Coda: 21060
10g. Citizan of What Country?: United States

**To Be Completed by Funeral Director**

11. Marifal Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armad Forcas? 1☒ Yas 2☐ No. If Yes, Giva Year or Datas: WW II
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White
15. Decedant's Education *(Specify only highast grada compiatad)* — Elamantary/Sacondary (0-12): 7; Colliaga (1-4or 5+):
16a. Decedent's Usual Occupetion *(Giva kind of work done during most of working life. DO NOT usa retired)*: Tool Group Supervisor
16b. Kind of Businass/Industry: Government
17. Fathar's Nama *(First, Middla, Last)*: Harry Stokes
18. Mothar's Nama *(First, Middla, Maidan Surname)*: Tippy McWilliams
19a. Informant's Name/Ralationship *(Type, Print)*: Paulette Rudisil/Niece
19b. Mailing Address *(Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code)*: 319 Wilson Blvd. S.W. Glen Burnie, MD 21061
20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of camatary, crametory or othar piace)*: Glen Haven MEm. Pk. — Data: Feb. 13, 2001
20c. Location - City or Town, State: Glen Burnie, MD
21. Signature of Funeral Service Licensee: David L. Ebaugh
22. Nama and Address of Facility: Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiretory errast, shock, or heart feilure. List only one cause on aach line.

Approximete Intervel Between Onsaf and Daath

Immediata Causa (Finel disease or condition resulting in daath)
a. End Stage Vascular Dementia — 5 yrs

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Ceuse (Disaasa or injury that initieted evants resulting in deeth) Last
b.
Due to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Othar significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.
CVA; Cerebrovascular Disease
Coronary Artery Disease
Parkinson's Disease

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings aveilable prior to complation of cause of daath? 1☐ Yes 2☒ No

25. Was casa refarrad to medical examiner? 1☐ Yas 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Rasidence 6☐ Othar *(Specify)*
27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarminad
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Straat and Numbar or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☒ **Cartifying Phyaician:** To tha best of my knowledga, daath occurred at the tima, data and placa, and dua to tha causa(s) and manner as statad. 2☐ **Madical Examinar:** On the basis of examinetion and/or invastigation, in my opinion, daath occurred at the tima, data and placa, and due to tha causa(s) and mannar stated.
29b. Signature and title of certifier: Gregorio M. Belloso M.D.
29c. Licansa numbar: D29505
29d. Data signed *(Month, Day, Yaar)*: 2-10-2001
30. Name and address of parson who completed causa of daath (Item 23e) (Type, Print): GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DR., SALISBURY, MD 21801

3

**State Registrar**

31. Date filad *(Month, Day, Yaar)*: FEB 16 2001
32. Registrar's Signatura: for D. Sparks

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04616

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Roby Lee Smith
2. Date of Death (Month, Day, Year): February 12 2001
3. Time of Death: 5:25am
4a. Facility Name *(If not institution, give street end number)*: Stella Maris
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 228-30-7311
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 10 1929
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 42 Lerner Court
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): Unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter
16b. Kind of Business/Industry: Home Building

17. Father's Name *(First, Middle, Last)*: Unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown Talbert

19a. Informant's Name/Relationship *(Type, Print)*: Debby Soper - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8830 Avondale Rd. Balt. MD 21234

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Balt./Wash. Crematory
Date: 2/14/01
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: Stephanie Alli
22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home, 2134 Willow Spring Rd. 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CANCER OF LARYNX
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* HOSPICE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed *(Month, Day, Year)*: 2/13/01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Date filed *(Month, Dey, Year)*: FEB 16 2001
32. Registrar's Signature: Geneva G Woods

ORIGINAL

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

FEBUARY 12, 2001 5:25 a.m.

ROBY SMITH

AMEND ITEM: #1 PER MD G792 2-16-01 WR.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04617

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month, Day, Year) | 3. Time of Death |
|---|---|---|
| JAMES ALLEN Sheckells (JAMES J. SHECKELLS) | 2 13 2001 | 6:55 AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| University of Maryland Medical Center | Baltimore | Baltimore City |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-44-8992 | 1☒M 2☐F | 55 Yrs. | | | April 5, 1945 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Lothian | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 650 Teton Drive | 20711 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) | 14. Race - American Indian, Bleck, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Master Electrician | Electrical |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Allan James Sheckells, Sr. | Dorothy Elizabeth Johnson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dolores M. Sheckells (Wife) | 650 Teton Drive, Lothian, MD 20711 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | St. James Cemetery | 02/16/2001 | Lothian, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Patrick J. Sheckells | Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset end Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as e consequence of): b. Urinary tract infection | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery (Month, Dey, Year) |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant et time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Cell cancer

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probebly 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of ceuse of deeth? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) |
|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rurel Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steted. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Yeer) |
|---|---|---|
| MD | P14688 | 2/13/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES MAXWELL LAI MD UNIVERSITY OF MARYLAND, Baltmor MD 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pegas 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04618

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Margaret Ann Siegel | FEBRUARY 13 2001 | 02:15 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GREATER BALTIMORE MEDICAL CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 234 42 8973 | 1☐M 2☒F | 73 Yrs. | | | Jan. 9, 1928 | West Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Middle River | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1143 Seneca Rd. | 21220 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Clerk | Drug Store |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Percy Clark | Myrtle Daniels |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| M. Thomas Mathis (Son) | 1143 Seneca Rd. Baltimore, Md. 21220 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Green Mount Crematory | 2/14/2001 | Baltimore, Md. |

21. Signature of Funeral Service Licensee: John W. Burkowske MO1091

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. PANCREATIC CANCER | 1 month |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| G.I.C. | D27730 | 2/13/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GARY COHEN, MD 6569 N. CHARLES ST. BALTIMORE, MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | Donna B. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Attending Physician or Hospital:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

SIEGEL MARGARET

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04619

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Mary | Irvine | Velthuis | February | 14 | 2001 | 12:40 am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Heritage Harbor Health & Rehabilitation | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 242-32-0608 | 1☐ M 2☒ F | 90 Yrs. | | | | | Oct. 12, 1910 | Kentucky |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Queen Annes | Queenstown | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 178 Greenwood Creek Road | 21658 | USA |

| 11. Marital Status | 12. Was Decedent Evar in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yas, Give Year or Datas: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedant's Education (Specify only highest grada completed) | | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Businass/Industry |
|---|---|---|---|
| Elemantary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Homemaker | Own Home |

| 17. Father's Nama (First, Middla, Last) | 18. Mother's Name (First, Middle, Maiden Sumama) |
|---|---|
| Charles Irvine | Blanche Baglin |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) |
|---|---|
| Pilip B. Velthuis (Son) | 7115 Counter Place, Burke, VA 22015 |

| 20a. Mathod of Disposition | 20b. Place of Disposition (Name of cemetary, crematory or othar place) | Date | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify) | Woodlawn Memorial Gardens | 02/17 2001 | Easton, MD |

21. Signatura of Funeral Service Licensee: Patrick Arell

22. Name and Addrass of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Advanced Dementia | XXX |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☑ **No** 3☐ **Probably** 4☐ **Unknown**

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was casa referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Othar: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) |
|---|---|
| | |

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| N. Javaheri MD | D41978 | 2-14-2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nader Javaheri M.D. 9801 #212 Greenbelt Rd. Lanham MD 20706

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | Barbara B. Sparks |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

AMEND ITEM: #8 PER F.H. G792 2-27-01 WR.

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04620

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ADA MARIE VAUGHN

2. Date of Death (Month, Day, Year): 02-13-2001

3. Time of Death: 7:30 AM.

4a. Facility Name (If not institution, give street and number): 711 New Pittsburg

4b. City, Town, or Location of Death: Turners Station

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-20-1748

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8-26-1924

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: TURNERS STATION

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 711 NEW PITTSBURG AVENUE

10f. Zip Code: 21222

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): JAMES E. WELLS

18. Mother's Name (First, Middle, Maiden Surname): EDMONIA M. COOK

19a. Informant's Name/Relationship (Type, Print): FELICIA WRIGHT/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 529 NEW PITTSBURG AVENUE, BALTO., MD. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST VET. CEM

Date: 2/21/2001

20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD. 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial infarction — immediate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Scott Feeser

29c. License number: D42232

29d. Date signed (Month, Day, Year): 2/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Feeser 2112 Dundalk Ave Baltimore MD 21222

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: Genevieve B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04621

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: DONALD KEITH WHITEHURST
2. Data of Death — Month: Feb. Day: 12 Yaar: 2001
3. Tima of Death: 8:45 A M
4a. Facility Nama *(If not institution, giva street and number)*: 1112 Mount Carmel Rd.
4b. City, Town, or Location of Daath: Parkton
4c. County of Daath: Baltimore

**Funeral Director**

5. Social Security Number: 220-24-0188
6. Sax: 1☐M 2☐F — X
7. Aga *(In yrs. last birthday)*: 72 Yrs.
If Undar 1 Year — Months / Days; If Undar 24 Hrs. — Hours / Min.
8. Data of Birth *(Month, Day, Year)*: July 27 1928
9. Birthplace *(Stata or Foraign Country)*: MD

Usual Residence of Decedent

10a. Stata: MD
10b. County: Baltimore
10c. City, Town or Location: Parkton
10d. Insida City Limits: 1☐Yas 2☒No — X
10e. Street and Number: 1112 Mount Carmel Rd.
10f. Zip Coda: 21120
10g. Citizan of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced — X
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No — X — If Yas, Give Yaar or Datas: '50-'55
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐Yes 2☒No — X — *Specify:*
14. Rece - Amarican Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada compiatad)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Guion Gladstone Whitehurst
18. Mothar's Name *(First, Middla, Maidan Surnama)*: Rhea Gardner

19a. Informant's Name/Ralationship *(Type, Print)*: Shirley Mears Whitehurst/wife
19b. Mailing Addrass *(Straat and Numbar or Rural Routa Number, City or Town, State, Zip Coda)*: 1112 Mount Carmel Rd., Parkton, MD 21120

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from Stata 4☐Donation 5☐Other *(Specify)* — X
20b. Placa of Disposition *(Nama of cematary, crematory or other placa)*: Balto. Wash. Crematory — Data: 2/14/01
20c. Location - City or Town, Stata: Laurel, MD

21. Signature of Funaral Service Licensee: Lowell M. Lemmon
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach line. — Approximata Intarval Betwaan Onset and Death

Immediata Causa (Final disease or condition resulting in death)
a. PROSTATE CARCINOMA
Dua to (or as a consequence of):
b.
Due to (or es a consequence of):
c.
Dua to (or as a consaquenca of):
d.

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or injury thet initiated events rasulting in daath) Last

tF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yas, outcome of pragnancy 1☐Liva birth 2☐Fatal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Other *(specify)* 9☐Unknown
23d. Data of delivary — Month Dey Year

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying causa givan in Part I.
Arteriosclerotic Cardiovascular Disease

23a. Did tobacco usa contributa to the causa of daath? 1☐Yes 2☒No 3☐Probably 4☐Unknown
24a. Was an autopsy performed? 1☐Yas 2☒No
24b. Were autopsy findings available prior to completion of ceuse of daath? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yas 2☒No
26. Place of Daath *(Check only one)* — Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Othar: 4☐Nursing Homa 5☒Residanca 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not be determinad
28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascriba how injury occurred
28a. Placa of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Straat and Number or Rural Route Number, City or Town, State)*

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Cartifiar *(Check only one)*: 1☒**Certifying Phyaician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and manner as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, date and pleca, and dua to tha causa(s) and mannar stated.
29b. Signatura and title of certifier: Barry Josephs
29c. License numbar: D26637
29d. Date signad *(Month, Day, Year)*: 2/13/01
30. Nama and address of person who completed causa of daath (Item 23a) (Typa, Print): Barry Josephs, M.D. 7600 Osler Dr., Suite 311, Towson, MD 21204

**State Registrar**

31. Date filed *(Month, Dey, Yeer)*: FEB 16 2001
32. Registrar's Signatura: Bonnie D. Sparks

DHMH 17 Rav 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04622

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): May Wilhelm
2. Date of Death: Month: February Day: 11 Year: 2001
3. Time of Death: 7:30 PM
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-07-6719
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 3, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6825 Cantfield Road 10B
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): John F.A. Wilhelm
18. Mother's Name (First, Middle, Maiden Surname): Rose Dyotte

19a. Informant's Name/Relationship (Type, Print): Andrew W. Hudak/friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2829 Montebello Terr Baltimore, MD 21214

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Christopher Davis MD
29c. License number: D0055609
29d. Date signed (Month, Day, Year): February 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Davis 7401 West Belvedere Avenue, Baltimore, Maryland 21215

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-0827-510
CJ
Michael Williams

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23,27,&28a-f per ME on 02/16/01 SS

# Certificate of Death

Reg. No. 2001 04623

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|
| Michael Wayne Williams, Jr. | February | 13 | 2001 | 11:45 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1523 Baldwin Street | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 215-86-5979 | 1☒M 2☐F | 30 Yrs. | | | | | March 12,1970 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1215 Union Avenue | 21211 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| ☒1 Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes ☒2 No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 9 | | Home Improvements | ARC Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Michael Williams, Sr. | Marion |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Marion Williams (Mother) | 1215 Union Avenue Baltimore, Maryland 21211 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| ☒1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Meadowridge Memorial | 2/17/01 | Dorsey,Maryland |

21. Signature of Funeral Service Licensee ▶ Burgee Henss Carpenter

22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, Maryland 21211

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. NARCOTIC INTOXICATION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnent in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☑ Yes 2☐ No | 1☑ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined | found: 2-13-01 | found: 11:30 PM | 1☐ Yes 2☒ No | unknown |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| other residence | 1523 Baldwin St., Balto., MD |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ M.D. | O.C.M.E. | February 14, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | ▶ |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04624

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Doris | B. | Wegrzyn | February | 13 | 2001 | 2:00 am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Heritage Harbor Health & Rehabilitation | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 047-07-4886 | 1☐ M 2☒ F | 86 Yrs. | | | | | Oct. 21, 1914 | Connecticut |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| CT | Fairfield | Bridgeport | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2768 Madison Avenue | 06430 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Receptionist | Computer |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Christian E. Fritz | Tunis Marxs |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| George J. Cameron, Jr. (SON) | 1462 Justin Place, Crofton, MD 21114 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Long Hill Cemetery | 02/17 2001 | Trumbull, Connecticut |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Patrick J. Arnold | Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. Coronary Artery disease | yrs |
| Due to (or as a consequence of): | b. Non-Hodgkins Lymphoma | yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. chronic obstructive pulmonary disease | yrs |
| Due to (or as a consequence of): | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| N. Tavakoli MD | D41978 | 2-13-2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Tavakoli 9801 Greenbelt Rd Suite 212 Lanham MD 20706.

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | L. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-0831-510
B.K.S
JAMES WHITE

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04625

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| JAMES O. WHITE | FEB. 14, 2001 | 0124 AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHNS HOPKINS HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-36-9518 | 1[X] M 2[ ] F | 62 Yrs. | | | 11-3-38 | NC |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | 1[X] Yes 2[ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2015 N. Washington St. | 21213 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[ ] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Welder | Shipyard |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Eddie White | Sarah Mae Wilson |

| 19a. Informant's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Charles White | 2015 N. Washington St. Balto., MD 21213 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | White Family Cem. | 02/21/2001 | Jacksonville, NC |

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD. 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset end Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Arteriosclerotic Cardiovascular Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1[ ] Yes 2[ ] No 9[ ] Unknown | 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnent at time of death 5[ ] Other (specify) 9[ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1[ ] Yes 2[X] No | 1[ ] Yes 2[ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1[X] Yes 2[ ] No | Hospital: 1[ ] Inpatient 2[X] ER/Outpatient 3[ ] DOA | Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | | M | 1[ ] Yes 2[ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1[ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J. M. T. | O.C.M.E | FEB. 14, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | James G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0784-005
FRANCIS M. WESSELS
ASP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04626

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Francis M. Wessels | FEBRUARY 11 2001 | 01008 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1630 MUSSULA ST. | | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-20-3841 | 1☒M 2☐F | 75 Yrs. | | | 9/23/1925 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Baltimore | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1630 Mussula Road | 21286 | U.S.a |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Machinist | Trucking |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Morton Wessels | Ruth Bichell |

| 19a. Informant's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Helen L. Wessels/Wife | 8114 Sagamore Road Baltimore, Maryland 21237 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Parkwood Cemetery | 2/16/01 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Curtis A. Gladden | John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive and Atherosclerotic

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b. Cardiovascular Disease

Due to (or as a consequence of):
c.

Due to (or as a consequenca of):
d.

| IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal deeth 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☑Yes 2☐No | 1☑Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residenca 6☒Other (Specify) SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) | 28f. Location (Street end Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ J. Pestaner M.D. | O.C.M.E | FEBRUARY 12,2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Yeer) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | ▶ Brenda G Sparks |

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Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04627

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANNA MAE ADAMS
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 11:54 A.M.
4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 218-60-1249
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 27, 1934
9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residance of Decedent

10a. State: WV
10b. County: MINERAL
10c. City, Town or Location: RIDGELEY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3 RIDGELEY STREET
10f. Zip Code: 26753
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): ALONZO J. ZIES
18. Mother's Name (First, Middle, Maidan Surneme): HARRIETT PARLETT

19a. Informant's Name/Relationship (Type, Print): JAMES R. ADAMS / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 129 - RIDGELEY, WV 26753

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): CUMBERLAND CREMATORY
Date: 2/6/2001
20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Herbert R. Upchurch
22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

**Physician /Medical Examiner**

23a. Part1. Enter the diseasa, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart tailure. List only one cause on each lina.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in daath)
a. Acute pulmonary edema — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Peripheral vascular disease — years

Due to (or as a consequance of):
c. Lung cancer — months

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.
coronary artery disease, status post coronary artery bypass graft, acute congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy tindings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha time, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D40693
29d. Data signed (Month, Day, Year): 2/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Samir A. Elian, M.D. 921 Seton Drive, Cumberland, MD 21502

**State Registrar**

31. Date filed (Month, Day, Year): FEB 0 6 2001
32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that tha death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

5
MS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04628

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MURIEL AGATHA AVIS

2. Date of Death (Month, Day, Year): JANUARY 30 2001

3. Time of Death: 1:40 PM

4a. Facility Name (If not institution, give street and number): DOCTORS COMMUNITY HOSPITAL

4b. City, Town, or Location of Death: LANHAM

4c. County of Death: PRINCE GEORGES

**Funeral Director**

5. Social Security Number: 579-76-9752

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4-27-1907

9. Birthplace (State or Foreign Country): JAMAICA

Usual Residence of Decedent

10a. State: MD

10b. County: PRINCE GEORGES

10c. City, Town or Location: HYATTSVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3109 LANCER DRIVE

10f. Zip Code: 20782

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH BARRETT

19a. Informant's Name/Relationship (Type, Print): CYNTHIA BECKFORD - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3109 LANCER DR., HYATTSVILLE, MD 20782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): FT. LINCOLN CEMETERY

Date: 02-08-01

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH. DC 20001

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Emboli — 1 week?

Due to (or as a consequence of):

b. Deep Vein Thrombosis — 1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E Flores MD

29c. License number: D1422

29d. Date signed (Month, Day, Year): 1/31/01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): EDUARDO FLORES - 5711 SARVIS AVE. Riverdale MD 301 864 7444

**State Registrar**

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04629

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary S. Atkins
2. Date of Death Month Day Year: Jan. 28 2001
3. Time of Death: 6:00 pm
4a. Facility Name (If not institution, give street and number): Heartland Nursing Facility
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 579-26-7247
6. Sex: 1☐ M 2☒F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 16, 1912
9. Birthplace (State or Foreign Country): Pittsboro, NC

Usual Residence of Decedent

10a. State: D.C.
10b. County: N/A
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1136 Buchanan St. N.W.
10f. Zip Code: 20011
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Head Housekeeper
16b. Kind of Business/Industry: Fed. Government

17. Father's Name (First, Middle, Last): Henry Snipes
18. Mother's Name (First, Middle, Meiden Surname): Viola Brooks

19a. Interment's Name/Relationship (Type, Print): Thomasine Cox/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1136 Buchanan St. N.W. Washington, D.C. 20011

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Memorial Cem Date: 2-1-2001
20c. Location - City or Town, State: Suitland, Md.

21. Signature of Funeral Service Licensee: J. L. Marshall
22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARREST
Due to (or as a consequence of):
b. CORONARY ARTERIOSCLEROSIS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CEREBROVASCULAR ACCIDENT
HYPERTENSION
DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: 042749
29d. Date signed (Month, Day, Year): 2/2/01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): RAYMOND NWADIUKO 9831 GREENBELT RD STE 107 GREENBELT MD 20706

**State Registrar**

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04630

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CORNELIUS ALSTON
2. Date of Death: Month 01 Day 25 Year 2001
3. Time of Death: 2:30AM
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MD MEDICAL SYSTEM
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CITY

**Funeral Director**

5. Social Security Number: 241-42-3109
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 68 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 18, 1932
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: P.G.
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 6309 Longfellow Street
10f. Zip Code: 20737
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 10/53 - 9/55
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☒ Yes 2 ☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronics
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Clarence Alston
18. Mother's Name (First, Middle, Maiden Surname): Nelonia McAdams

19a. Informant's Name/Relationship (Type, Print): Walter Johnson/Son in Law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 66 Sarah Lane Middletown, New York 10941

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Riverdale Crematory
Date: 2-2-2001
20c. Location - City or Town, State: Riverdale, MD

21. Signature of Funeral Service Licensee: Belva J. Jenkins
22. Name and Address of Facility: J.B. Jenkins Funeral Home, 7474 Landover Road, Landover Md. 20785

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PNUEMONIA
Due to (or as a consequence of):
b. PULMONARY ASPERGILLOS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Boateng MD
29c. License number: AM4176435B9995
29d. Date signed (Month, Day, Year): 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PERCY BOATENG 22 SOUTH GREENE ST, DEPT. OF SURGERY, BALTIMORE MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04631

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Francis Frederick Albrecht

2. Date of Death (Month, Day, Year): JANUARY 25 2001

3. Time of Death: 5:05 AM

4a. Facility Name *(If not institution, give street and number)*: Dr. Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 302 16 1792

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Dec 17, 1925

9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Indian Head

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No XXX

10e. Street and Number: 10 Beth Court

10f. Zip Code: 20640

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales

16b. Kind of Business/Industry: Electronics

17. Father's Name *(First, Middle, Last)*: Adulf Albrecht

18. Mother's Name *(First, Middle, Maiden Surname)*: (Unknown) Hacker

19a. Informant's Name/Relationship *(Type, Print)*: Anne Albrecht (WIFE)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 10 Beth Court, Indian Head, Maryland 20640

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Trinity Memorial Gardens — Date: Jan 29, 2001

20c. Location - City or Town, State: Waldorf, Maryland

21. Signature of Funeral Service Licensee: M A D Park

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

**To Be Completed by Funeral Director**

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. Aspiration Pneumonitis — days.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa given in Part I.

Sepsis C. difficili Colitis, Atrial fibrillation, Renal insufficiency, urosepsis. Atherosclerotic vascular disease

23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N Shai M.D

29c. License number: D 48213

29d. Date signed *(Month, Dey, Year)*: January 25th 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Neelam Ashai 4410 74th Ave landover Hills MD 20784

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

10 / IVa

**State Registrar**

31. Date filed *(Month, Dey, Year)*: JAN 30 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04632

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Clarence M. Addison

2. Date of Death (Month, Day, Year): January 28, 2001

3. Time of Death: 1430

4a. Facility Name *(If not institution, give street and number)*: 6012 Crown Street

4b. City, Town, or Location of Death: Seat Pleasant

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 217-32-4940

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7/31/34

9. Birthplace *(State or Foreign Country)*: Forestville,Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: P.G.

10c. City, Town or Location: Seat Pleasant

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6012 Crown Street

10f. Zip Code: 20743

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Agriculture

17. Father's Name *(First, Middle, Last)*: George I. Addison,Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Katie Young

19a. Informant's Name/Relationship *(Type, Print)*: Joseph Addison/Brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3200 Oak St.,Upper Marlboro,Md.20774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Washington Nat'l. Cem.

Date: 2/2/01

20c. Location - City or Town, State: Suitland,Md.

21. Signature of Funeral Service Licensee: Larry N. Grant

22. Name and Address of Facility: H.S.Washington & Sons Co.,Inc. 4925 Burroughs Ave.,N.E.,Wash.,D.C.20019

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Hypertensive Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvester, DO

29c. License number: H0055927

29d. Date signed *(Month, Day, Year)*: January 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04633

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): PAUL H. ALBAN
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 9:45 PM

4a. Facility Name (If not institution, give street and number): National Lutheran Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-18-3339
6. Sex: X M 2 F
7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 29, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 9701 Veirs Drive
10f. Zip Code: 20850
10g. Citizen of What Country?: USA

11. Marital Status: 1 X Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No — If Yes, Give Yaar or Detas: 1943-44
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cartographer
16b. Kind of Business/Industry: Army Map Service

17. Father's Name (First, Middle, Last): Julian N. Alban
18. Mother's Name (First, Middle, Maiden Surneme): Elsie B. Kaun

19a. Informent's Name/Reletionship (Type, Print): Betty A. Ward - Cousin
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 11318 Crickenberger Rd. New Market, MD 21774

20e. Method of Disposition: 1 Buriel 2 X Cremation 3 Removel from State 4 Donation 5 Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Metropolitan Crematory
Dete: 1/30/01
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funaral Service Licensee: W. M. Hysong
22. Name and Address of Facility: Hysong Company, Washington, DC

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Final diseese or condition resulting in death)
e. Sudden cardic death — immediate
Due to (or es e consequence of):
b. Coronary artery diseas — 10 years
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
Cerebral vas cular accident
Chranc obstructive pulmonary diseas
Dementic

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24e. Wes en eutopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Wes case referred to medical examiner? 1 Yes 2 X No

26. Place of Deeth (Check only one): Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA — Other: X 4 Nursing Home 5 Residenca 6 Other (Specify)

27. Menner of Deeth: 1 X Naturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28e. Data of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner es steted. 2 Medfcal Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) end menner steted.

29b. Signature end title of certifier: [signature]
29c. License number: D500612
29d. Date signed (Month, Day, Year): January 29, 2001

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): SAMUEL G. MILLER 9701 Veirs Drive Rockville, MD 20850

**State Registrar**

31. Dete filed (Month, Dey, Yeer): JAN 31 2001
32. Registrer's Signetura: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 01631

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Frances Hazel Bowers

2. Date of Death (Month, Day, Year): January 30, 2001

3. Time of Death: 0125

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 219-12-1377

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 13, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12212 Cedar Crest Avenue

10f. Zip Code: 21740

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): William Albert Burger

18. Mother's Name (First, Middle, Maiden Surname): Belle Mary Burger

19a. Informant's Name/Reletionship (Type, Print): Robert K. Bowers Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12212 Cedar Crest Avenue Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, cremetory or other piece): Cedar Lawn Memorial Park

Date: 2/3/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich

22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street Hagerstown, Maryland 21740

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List *only* one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Arteriosclerotic Heart Disease

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Abdominal Bleeding

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 16684

29d. Date signed (Month, Day, Year): 1-31-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Landizabal 382 S. Cleveland Ave. Hag. Md 21740

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Bowers, Frances

Division of Vital Records, P.O. Box 68760,

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04635

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LEONA CATHERINE BOWERS
2. Data of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 0600
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

**Funeral Director**

5. Social Security Number: 214-09-3988
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 14, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 268 S. Potomac St.
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cafeteria Worker
16b. Kind of Business/Industry: Hotel

17. Father's Name (First, Middle, Last): Daniel E. Shrader
18. Mother's Name (First, Middle, Maiden Surname): Leah C. Grumbine

19a. Informant's Name/Relationship (Type, Print): Lisle Cramer/Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20017 Leitersburg Pike, Hagerstown, MD 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park
Date: Feb. 3
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Douglas A. Fiery
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21742

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

Bowers, Leona

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — minutes

Due to (or as a consequence of):
b. Coronary Artery Disease — >5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Previous Myocardial Infarction — 2 weeks

Due to (or as a consequence of):
d. Congestive Heart Failure — 2 weeks

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Insulin Dependent Diabetes
Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. Cikcarell
29c. License number: MD0052136
29d. Date signed (Month, Day, Year): January 31, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Cikcarell. 3 Byrkit Drive Williamsport, Maryland

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

31. Data filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

VOID

CERTIFICATE #

01-04636

SEE

CERTIFICATE #

01-01558

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State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04637

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ROBERT ALLEN BRADSHAW
2. Date of Death Month Day Year: JAN. 29, 2001
3. Time of Death: 9:AM
4a. Facility Name *(If not institution, give street and number)*: Salisbury Center; Genesis ElderCare
4b. City, Town, or Location of Death: Salisbury, Md.
4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 225-26-2369
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 19, 1926
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1026 Heron Court
10f. Zip Code: 21804
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 ☒ Yes 2 ☐ No — If Yas, Give Year or Detes: WW II
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementery/Secondary (0-12): 12 — Collega (1-4or 5+): 4
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant
16b. Kind of Business/Industry: DuPont

17. Fethar's Name *(First, Middle, Last)*: Paul Cox Bradshaw
18. Mother's Nama *(First, Middle, Meiden Surneme)*: Gladys Ivy Sowers

19a. Informent's Neme/Relationship *(Type, Print)*: Virginia H. Bradshaw/Wife
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1026 Heron Court, Salisbury, MD 21804

20e. Method of Disposition: 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donetion 5 ☒ Other *(Specify)* Entombment
20b. Place of Disposition *(Nema of cemetery, cremetory or other place)*: Wicomico Memorial Park
Dete: 2/2/01
20c. Location - City or Town, Stete: Salisbury, MD

21. Signature of Funaral Sarvice Licensee: David A. Thompson M0105i
22. Name and Address of Facility: Holloway Funeral Home Professional Association, 501 Snow Hill Rd., Salisbury, MD 21804

**Physician /Medical Examiner**

23a. Part1. Enter tha disease, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiretory errest, shock, or haart failura. List only ona cause on aach lina.

Approximate Intarval Batwaan Onset end Death

Immediata Causa (Finel disaase or condition resulting in deeth)
e. Ca of Lung c mets to Liver
Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Cause (Disease or injury thet initieted events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings available prior to completion of causa of daath? 1 ☐ Yes 2 ☐ No

25. Wes case refarred to medical axaminar? 1 ☐ Yas 2 ☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Menner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Data of Injury *(Month, Dey Year)*
28b. Tima of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, daeth occurred et the time, data end placa, and due to the cause(s) end menner as steted. 2 ☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the tima, dete and place, and dua to tha ceusa(s) and mennar statad.

29b. Signetura and title of certifier: B. Horner
29c. License number: D13053
29d. Data signed *(Month, Dey, Year)*: 1/30/01

30. Neme end eddress of person who completed causa of death (Item 23a) (Type, Print): WILLIAM BEN HORNER, 100 POWER ST., SALISBURY, MD 21804

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 0 1 2001
32. Registrar's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

ROBERT BRADSHAW
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8+1VA
DQ

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04638

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Mason Baer

2. Date of Death — Month: JANUARY Day: 30 Year: 2001

3. Time of Death: 6:30 PM

4a. Facility Name *(If not institution, give street and number)*: Doctor's Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 390-07-8209

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 29, 1916

9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9885 Greenbelt Road

10f. Zip Code: 20706

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman

16b. Kind of Business/Industry: Raleigh's Haberdashery

17. Father's Name *(First, Middle, Last)*: Benjamin King Baer

18. Mother's Name *(First, Middle, Maiden Surname)*: Celia Keidan

19a. Informant's Name/Relationship *(Type, Print)*: Reverend Timothy King Baer - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3107 63rd Avenue, Cheverly, MD 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 02/02/01

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Alfred Miller

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxic Encyphalopathy — One Week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Severe Chronic Obstructive Pulmonary Disease — Years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rointan Farahi M.D.

29c. License number: D43446

29d. Date signed *(Month, Day, Year)*: January 31, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Rointan Farahi-Far, M.D., 9801 Georgia Avenue, Ste 3-35, Silver Spring, MD 20902

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(10)

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend #7.Per FH PGC 2-1-01 cr

# Certificate of Death

Reg. No. 2001 04639

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GEORGE BURKE
2. Dete of Deeth: Month 1 Day 09 Year 01
3. Time of Death: 9:45 PM
4a. Facility Neme (If not Institution, give street end number): CHERRY LANE NURSING HOME
4b. City, Town, or Location of Deeth: LAUREL
4c. County of Deeth: PG

**Funeral Director**

5. Social Security Number: 578-02-6545
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): ~~77~~ 76 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 4-23-24
9. Birthplece (State or Foreign Country): VI's Virgin Island

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street end Number: 9001 Cherry Lane
10f. Zip Code: 20708
10g. Citizen of Whet Country?: U.S.A.
11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - Amarican Indien, Black, While, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Special Ed. | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A
17. Fether's Name (First, Middle, Last): George Burke
18. Mother's Neme (First, Middle, Maiden Sumeme): Mariel Taylor
19a. Informent's Name/Relationship (Type, Print): Abigail L. Taylor (Great Niece)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 12504 Granite Ridge Dr. North Potomac, Md. 20878
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Nema of cemetery, cremetory or othar place): Northern Virginia Crematory
Date: 01-31-01
20c. Location - City or Town, Stale: Arlington, Va.
21. Signatura of Funaral Service Licensee: Wanda C. Bacon CCO361
22. Nama and Address of Facility: Bacon Funeral Home, Inc. 3447 14th St., N.W. Washington, D. C. 20010

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errast, shock, or heart feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset and Deeth

Immediate Ceuse (Final disease or condition resulting in death): e. Pneumonia — 36 hours

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Lest:

b. Due to (or as a consequenca of):

c. Due to (or es a consequance of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Chronic obstructive Pulmonary Disease

23b. Did tobacco uee contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes en eutopsy performed? 1 ☒ Yas 2 ☐ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical exeminer? 1 ☒ Yes 2 ☐ No

28. Place of Deeth (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Phyeiclen:** To the besl of my knowledge, death occurrad at the time, dete end place, and due to the ceuse(s) and menner es steted. 2 ☐ **Medical Examiner:** On the besis of examinetion end/or investigation, In my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: Ad Magby MD

29c. License number: Maryland D25430

29d. Date signed (Month, Dey, Year): January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John MARGOLIS, MD 13952 Baltimore Ave. Laurel, MD 20707

**State Registrar**

31. Deta filed (Month, Dey, Year): FEB 01 2001

32. Registrar's Signature: Bonnie D. Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(2)

01-0309-033
jhm
DOUGLAS
BRAXTON

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04640

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DOUGLAS E BRAXTON
2. Date of Death: Month JANUARY Day 17, Year 2001
3. Time of Death: 18:30 PM
4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

**Funeral Director**

5. Social Security Number: 220-08-9699
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 31 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5/16/69
9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State: MD
10b. County: PG
10c. City, Town or Location: LANDOVER
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7719 PENBROOK PLACE
10f. Zip Code: 20785
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10TH GRADE; College (1-4or 5+): NONE
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECURITY GUARD
16b. Kind of Business/Industry: SECURITY

17. Father's Name (First, Middle, Last): WALTER A. BRAXTON, SR.
18. Mother's Name (First, Middle, Maiden Surname): RUTH PITTARD

19a. Informant's Name/Reletionship (Type, Print): RUTH E. BRAXTON (MOTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4321 KINMOUNT ROAD, LANTHAM, MD., 20706

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): GLENWOOD CEMETERY; Date: 1/27/2001
20c. Location - City or Town, State: WASHINGTON, DC

21. Signature of Funeral Service Licensee #CC0273: Juan Smith
22. Name and Address of Facility: JOHN T. RHINES CO.,INC. 3030 12TH ST NE, DC 20017

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

2

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Multiple injuries with complications

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [ ] Netural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year): 1-13-2001
28b. Time of Injury: 0350 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject was struck by motor vehicle
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify): Street
28f. Location (Street end Number or Rural Route Number, City or Town, State): Martin Luther King Ave Prince Georges County, Maryland

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signeture end litle of certifier: Steph L Mack, M.D.
29c. License number: OCME
29d. Date signed (Month, Dey, Year): JANUARY 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Dey, Year): JAN 30 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04641

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY BOROKINNI
2. Date of Death (Month, Day, Year): January 23, 2001
3. Time of Death: 7:10 PM
4a. Facility Name (If not institution, give street and number): 4501 Rena Road #4
4b. City, Town, or Location of Death: Suitland
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 577-76-1065
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 45 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 23, 1955
9. Birthplace (State or Foreign Country): Trenton, S.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georg's
10c. City, Town or Location: Suitland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4501 Rena Road #4
10f. Zip Code: 20746
10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Financial Specialist
16b. Kind of Business/Industry: United States Gov't

17. Fether's Nema (First, Middle, Last): William Griffin
18. Mother's Neme (First, Middle, Maiden Surneme): Mattie Bell Mckie

19a. Informent's Name/Reletionship (Type, Print): Juanita Griffin/ Sister
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 7017 Old Branch Ave. Temple Hills, Md. 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca): Cedar Hill Cemetery
Dete: 1/30/01
20c. Location - City or Town, State: Suitland, Md.

21. Signeture of Funerel Service Licensee: Keith A Savage M0105
22. Name end Addrass of Feciliry: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md 20747

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complications that caused tha deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert teilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Finel disaese or condition resulting in deeth)
e. Metastatic Carcinoma of Thyroid

Due to (or es e consequenca of):

Sequentielly list conditions, if any, leading to immediete causa. Enter Underlying Ceuse (Disease or Injury thet Initiated events resulting in death) Lest
b. Metastases to Lung,Pleura and Bones — 2 Yrs.

Due to (or es e consequence of):
c.

Dua to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in tha underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: Sajeev Anand, M-D.
29c. License number: D33482
29d. Dete signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Sajeev Anand, M.D. 7343-A Hanover Pkwy. Greenbelt, Md. 20770

**State Registrar**

31. Data filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

6

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04642

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lorraine J. Barnes

2. Date of Death: Month: January Day: 24 Year: 2001

3. Time of Death: 1133 A

4a. Facility Name (If not institution, give street and number): 2054 Chadwick Terrace

4b. City, Town, or Location of Death: Temple Hills

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 579-50-7050

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min.

8. Date of Birth (Month, Day, Year): May 31, 1939

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Temple Hill

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 2054 Chadwick Terrace

10f. Zip Code: 20748

10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Raca - American Indien, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highest greda completed): Elementery/Secondery (0-12): | Collega (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Correctional Officer

16b. Kind ol Business/Industry: Law Enforcement

17. Father's Neme (First, Middle, Last): Frank James, Sr.

18. Mother's Neme (First, Middle, Maiden Surneme): Lelia Mae Adams

19a. Informant's Neme/Relationship (Type, Print): Willie Barnes, Jr./ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11235 Oakleaf DR. #917 Silver Spring, Md. 20901

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel Irom Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece ol Disposition (Name of cemetery, cremetory or other place): Harmony Memorial Park | Date: 1/30/01

20c. Location - City or Town, Stete: Landover, Md.

21. Signeture of Funerel Servica Licensee: Keith A. Furey M01055

22. Nama and Address ol Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/forestville, Md. 20747

**Physician /Medical Examiner**

23a. Pert I. Enter the diseage, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert leilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in deeth): e. Arteriosclerotic Cardiovascular Disease

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immadiete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion ol cause ol death? 1☐ Yes 2☐ No

25. Was case relarred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the cause(s) and manner steted.

29b. Signature end title of certifier: Salvador Sylvester DO

29c. Licensa number: H0055927

29d. Date signed (Month, Dey, Year): January 25, 2001

30. Neme end address ol person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester 3001 Hospital Drive, Cheverly, Maryland 20785

**State Registrar**

31. Dete liled (Month, Dey, Year): JAN 29 2001

32. Registrer's Signature: Bernice G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04643

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Guida Viola Bell
2. Date of Death — Month: January Day: 25, Year: 2001
3. Time of Death: 7:25 pm
4a. Facility Name (If not institution, give street and number): Doctor's Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 217-70-8815
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 15, 1924
9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: New Carrollton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6410 Kaslo Court
10f. Zip Code: 20784
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementery/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Avon District Manager
16b. Kind of Business/Industry: Avon, Inc.

17. Father's Neme (First, Middle, Last): John Edmonds
18. Mother's Name (First, Middle, Maiden Surname): Bertha Harper

19a. Informant's Neme/Relationship (Type, Print): Diane R. Nusser - Daughter
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 10034 Marguerita Avenue, Glenn Dale, MD 20769

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other place): Metropolitan Crematory
Date: 01/28/01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signeture of Funerel Service Licensee: Alfred Miller
22. Neme end Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

**Physician /Medical Examiner**

23a. Pert1. Ente(the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death)
e. CARDIAC ARREST — 0

Due to (or es e consequenca of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest
b. CARDIOMYOPATHY

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Pert II. **Other eignificant conditfone** contributing to death but not resulting in the underlying cause given in Pert f.

23b. Dfd tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and pleca, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: Roger B Ingham M.D.
29c. License number: D0 5891
29d. Date signed (Month, Day, Year): January 27, 2001

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Roger Ingham, M.D. 6510 Kenilworth Avenue #2400, Riverdale, Maryland

**State Registrar**

31. Date filed (Month, Dey, Year): JAN 29 2001
32. Registrer's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04644

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gertrud Burchardt-Hartmann
2. Date of Death (Month, Day, Year): January 24, 2001
3. Time of Death: 6:30 am
4e. Facility Name (If not institution, give street and number): Prince George's Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 113-26-2901
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 11, 1911
9. Birthplace (State or Foreign Country): Germany

Usuel Residence of Decedent

10e. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: College Park
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6200 Westchester Park Drive
10f. Zip Code: 20740
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): | Collegе (1-4or 5+): 3
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Law Firm

17. Father's Neme (First, Middle, Last): Otto Hartmann
18. Mother's Name (First, Middle, Maiden Sumeme): Clara Juergens

19a. Informant's Neme/Retetionship (Type, Print): Horst Hartmann - Brother
19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9406 Tuckerman Street, Lanham-Seabrook, MD 20706

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Ptece of Disposition (Name of cemetery, cremetory or other plece): Metropolitan Crematory
Dete: 01/28/01
20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signeture of Funerel Service Licensee: ▶ Alfa Miller
22. Name and Address of Fecility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

**Physician /Medical Examiner**

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervet Between Onset and Death

Immediate Cause (Finet diseese or condition resulting in death)
a. CORONARY ARTERY THROMBOSIS
Due to (or es e consequence of):
Sequentiellty list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b. CORONARY ARTERY DISEASE
Due to (or es e consequence of):
c.
Due to (or es a consequence of):
d.

Pert ft. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicat examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturet 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of tnjury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Ptece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: ▶ Hector D. Collison
29c. License number: M075
29d. Date signed (Month, Day, Year): January 27, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Hector Collison, M.D. 8401 Colesville Road #310, Silver Spring, MD 20910

**State Registrar**

31. Date filed (Month, Dey, Year): JAN 29 2001
32. Registrer's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Amended #4 a, Per PHY. GC, 1/29/01 — **Certificate of Death** — Reg. No. 2001 04645

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Maude Louise Brown
2. Dete of Deeth: Month 01 Dey 23 Yeer 2001
3. Time of Deeth: 10:45 AM
4e. Fecility Neme (If not institution, give street and number): GLADYS SPELLMAN SPECIATY CENTER ~~Prince George Hoopital~~
4b. City, Town, or Location of Deeth: Cheverly, MD
4c. County of Deeth: Prince George's

**Funeral Director**

5. Social Security Number: 245-28-8398
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): July 27, 1923
9. Birthplece (State or Foreign Country): North Carolina

Usual Residence of Decedent

10e. Stete: MD
10b. County: Prince George's
10c. City, Town or Location: New Carrollton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5309 85th Avenue Apt #11
10f. Zip Code: 20784
10g. Citizen of Whet Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th; College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): House Wife
16b. Kind of Business/Industry: Private
17. Father's Name (First, Middle, Last): Willie Simmons
18. Mother's Name (First, Middle, Maiden Surname): Etta McCollum
19a. Informent's Name/Relationship (Type, Print): Michael Brown/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 201 I Street S.W. Washington, DC 20024
20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft Lincoln Cemetery
Date: 1-30-01
20c. Location - City or Town, Stete: Brentwood, MD
21. Signeture of Funeral Service Licensee: [signature]
22. Name end Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. — Approximete Interval Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in death): e. Brain stem stroke — WKS

Due to (or as a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest:
b. systemic Lupus erythromatosis — Months
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature] MD
29c. License number: D4878
29d. Date signed (Month, Day, Year): 1-24-2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Nader Tawakol 9801 Greenbelt Rd #212 Lanham MD 20706

**State Registrar**

31. Dete filed (Month, Day, Year): JAN 29 2001
32. Registrer's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(3)

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04646

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Nyambae Blake
2. Date of Death (Month, Day, Year): Jan. 23, 2001
3. Time of Death: 9:26 pm
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park, MD
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 578-80-0675
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-15-1948
9. Birthplace (State or Foreign Country): Sumbuya, WA

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3622 Dean Drive #N-5
10f. Zip Code: 20783
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pension Specialist
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Alfonsu Blake
18. Mother's Name (First, Middle, Maiden Surname): Francess Lefevre

19a. Informant's Name/Relationship (Type, Print): Madinatu Jalloh/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6327 Landover Rd #103 Cheverly, MD 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gelahun Cemetery
Date: 2-10-01
20c. Location - City or Town, State: Sumbuya, West Africa

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Metabolic Acidosis
Due to (or as a consequence of):
c. Renal Failure
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] Lawrence Simon MD
29c. License number: D36177
29d. Date signed (Month, Day, Year): Jan. 24, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lawrence Simon, M.D. Washington Adventist Hospital 7600 Carroll Ave. Takoma Park, MD 20912

**State Registrar**

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04647

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Marian Josephine Bailey

2. Date of Death Month: January Day: 22, Year: 2001

3. Time of Death: 11:00 a.m.

4a. Facility Name *(If not institution, give street and number)*: 4912 Queensbury Road

4b. City, Town, or Location of Death: Riverdale Park

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 506-16-1237

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 4, 1921

9. Birthplace *(State or Foreign Country)*: Nebraska

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Riverdale Park

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4912 Queensbury Road

10f. Zip Code: 20737

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Communication Specialist

16b. Kind of Business/Industry: Pentagon

17. Father's Name *(First, Middle, Last)*: Clifford Bailey

18. Mother's Name *(First, Middle, Maiden Surname)*: Zina Morris

19a. Informant's Name/Relationship *(Type, Print)*: Ann M. Ferguson - Friend

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4811 Oglethorpe Street, Riverdale Park, MD 20737

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Washington National Cemetery | Date: 01/31/01

20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: Henry L. Ferguson

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — One Day

Due to (or as a consequence of):

b. Atrial Fibrillation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Lymphocytic Leukemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis Cullen

29c. License number: D40216

29d. Date signed *(Month, Day, Year)*: January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Cullen, M.D., 5454 Wisconsin Avenue, Ste. #1625, Chevy Chase, MD 20815

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No 2001 04648

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: BEATRICE BING
2. Date of Death (Month, Day, Year): January 29, 2001
3. Time of Death: 5:45 A.M.
4a. Facility Name *(If not institution, give street and number)*: FUTURE CARE PINE VIEW
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 247-86-6799
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar. 3, 1910
9. Birthplace *(State or Foreign Country)*: Pineland, S.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Ft. Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3705 Ladd Avenue
10f. Zip Code: 20744-1850
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* African American

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Willie Devore
18. Mother's Name *(First, Middle, Maiden Surname)*: Carrie Garvin

19a. Informant's Name/Relationship *(Type, Print)*: Guerene M. DeCosta - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3705 Ladd Avenue, Fort Washington, MD 20744

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cem. Gillison Branch Bapt. Ch.
Date: 2/3/2001
20c. Location - City or Town, State: Pineland, SC

21. Signature of Funeral Service Licensee: John T. Stewart III
22. Name and Address of Facility: STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E., Washington, D. C.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic cardiovascular disease — yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D19431
29d. Date signed *(Month, Day, Year)*: 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank M. Ryan MD 11701 Livingston Rd #203 Ft. Washington MD 20744

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: pending D. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04649

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Elsie Alberta Blanchfield
2. Data of Death (Month, Day, Year): Feb. 5, 2001
3. Time of Death: 7:40 PM
4a. Facility Name (If not institution, giva street and number): Caroline Nursing Home
4b. City, Town, or Location of Death: Denton
4c. County of Death: Caroline

**Funeral Director**

5. Social Security Number: 214-32-5746
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): JUL.14,1920
9. Birthplace (State or Foraign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Caroline
10c. City, Town or Location: Federalsburg
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 616 Academy Avenue
10f. Zip Code: 21632
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Restaurant

17. Fathar's Nama (First, Middla, Last): James Loller
18. Mother's Name (First, Middle, Maiden Surnama): Mary Emma Craig

19a. Informant's Name/Relationship (Type, Print): William Blanchfield/Son
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 5896 Jester Rd., Federalsburg, MD 21632

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cemetery, cremetory or othar piece): Concord Cemetery
Data: 2/9/01
20c. Location - City or Town, Stata: Federalsburg, MD

21. Signature of Funaral Service Licensee: ▶ Michael F. Eskow
22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632

**Physician /Medical Examiner**

23a. Part1. Enter tha disease, or complications that caused the death. Do not enter tha mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximata Interval Between Onsat and Daath |
|---|---|---|
| Immediate Cause (Finel disease or condition rasulting in death) a. | PLEURAL EFFUSION | 5 MONTHS |
| Dua to (or as a consequence of): b. | CIRRHOSIS LIVER | 5 MONTHS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last — Dua to (or as a consequence of): c. | | |
| Dua to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

ANEMIA
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No
26. Placa of Death (Check only ona) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, data and place, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D0053815
29d. Data signed (Month, Day, Year): 02/06/01

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Wafik Zaki, MD 920 Market St., Denton, MD 21629

**State Registrar**

31. Data filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: ▶ [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pagas 1 and 2 should be filed within 72 hours afar death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that tha daath cartificate be executed within 24 hours afar daath. To the Funeral Director: Afar this certificate has been signed by tha attending physician and completely filled in by tha funaral director, paga 2 should be datached for usa as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black indelible ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04650

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MARTHA GAIL CORLEY

2. Data of Death Month / Day / Year: January 31, 2001

3. Time of Death: 1735

4a Facility Name *(If not institution, giva street and number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

**Funeral Director**

5. Social Security Number: 233-36-5266

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: OCT 3 1926

9. Birthplaca *(Stata or Foreign Country)*: W.VA.

Usual Rasidance of Decedent

10a. Stata: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 235 PACA STREET APT# 512

10f. Zip Coda: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amaricen Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Educetion *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): 12 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: HILLS DEPT STORE

16b. Kind of Businass/Industry: CLERK

17. Fathar's Nama *(First, Middla, Last)*: DARIUS BOYLES

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: FRANKIE CLEVELAND LEWIS

19a. Informant's Name/Ralationship *(Type, Print)*: DENVER CORLEY SON

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: RT# 1 BOX# 223 KINGWOOD, W.VA. 26537

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetery, crematory or othar place)*: CUMBERLAND CREMATORY

Data: FEB 1, 2001

20c. Location - City or Town, Stata: CUMBERLAND MARYLAND

21. Signatura of Funaral Sarvice Licensaa: Dale L. Merritt

22. Nama and Addrass of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused tha daath. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shock, or haart tailure. List only ona causa on aach lina.

Approximata Intarval Batween Onsat and Daath

Immediate Cause (Final disaasa or condition rasulting in daath)

a. Chronic Renal failure — 5 years

Dua to (or as a consequance of)

b. Diabetes Mellitus — 20 years

Sequentially list conditions, if any, leading to immadiata ceuse. Entar Undarlying Causa (Diseasa or Injury that initiated events rasulting in death) Last

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying ceusa givan in Part I.

- Hypertension
- Cellulitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa rafarrad to madical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar

29c. Licansa number: D0033280

29d. Data signed *(Month, Day, Yaar)*: Jan 31, 2001

30. Nama and addrass of person who complated ceusa of death (Item 23a) (Type, Print): Sunil Gupta M.D. 625 Kent Ave. Cumberland MD 21502.

**State Registrar**

31. Data filed *(Month, Day, Yaar)*: FEB 02 2001

32. Registrar's Signatura: Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

4

MS

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04651

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: MAE CATHERINE CLISE

2. Dete of Deeth: Month JAN Dey 31 Yeer 2001

3. Time of Death: 9:55 AM

4e Feciity Neme *(If not institution, give street end number)*: CUMBERLAND NURSING HOME

4b. City, Town, or Location of Deeth: CUMBERLAND

4c. County of Deeth: ALLEGANY

**Funeral Director**

5. Sociel Security Number: 215-36-9709

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 84 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: DEC 3, 1916

9. Birthplece *(Stete or Foreign Country)*: MARYLAND

Usuel Residence of Decedent

10a. Stete: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 11430 RED HILL SW

10f. Zip Code: 21502

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: ELEVATOR OPERATOR

16b. Kind of Business/Industry: RETAIL

17. Fether's Neme *(First, Middle, Last)*: OSCAR DREYER

18. Mother's Neme *(First, Middle, Maiden Surneme)*: FLORENCE STURTZ

19e. Informent's Neme/Reletionship *(Type, Print)*: ELSIE HAUSRATH-DAUGHTER

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 11425 RED HILL RD SW, CUMBERLAND, MD 21502

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: REST LAWN MEMORIAL GARDENS

Dete: FEB 3, 2001

20c. Locetion - City or Town, Stete: LAVALE, MD

21. Signeture of Funerel Service Licensee: Douglas S Hafer

22. Neme end Address of Feciility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502

**Physician /Medical Examiner**

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Cerebrovascular Accident — 2 years

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.: Dementia

23b. Did tobecco use contribute to the ceuse of deeth? 1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Locetion *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Dr. [illegible]

29c. License number: D0033280

29d. Dete signed *(Month, Dey, Yeer)*: Feb 2, 2001

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): DR. S. GUPTA 625 KENT AVE., CUMBERLAND, MD 21502

**State Registrar**

31. Dete filed *(Month, Dey, Yeer)*: FEB 02 2001

32. Registrer's Signeture: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health end Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04652

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Eula Cline

2. Date of Death: Month February Dey 4 Year 2001

3. Time of Death: 6:20 A.M.

4a. Facility Neme (If not institution, give street and number): Julia Manor Health Care Center

4b. City, Town, or Location of Deeth: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 218-30-9358

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): August 6, 1916

9. Birthplace (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Md.

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 333 Mill St.

10f. Zip Code: 21740

10g. Citizen of Whet Country?: U.S.A.

11. Merital Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodial Work

16b. Kind of Business/Industry: Maryland Ribbon Co.

17. Fether's Name (First, Middle, Last): Herman Clopper

18. Mother's Name (First, Middle, Maiden Sumeme): Harriet Provard

19a. Informent's Neme/Relationship (Type, Print): Nancy F. Startzman/Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 11600 Hopkins Lane Smithsburg, Md. 21783

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory, or other piece): Welsh Run Church Of The Brethren Cemetery

Dete: 2/7/01

20c. Location - City or Town, Stete: Welsh Run, Pa.

21. Signature of Funeral Service Licensee: ▶ H. Martin Zimmerman Jr.

22. Name end Address of Fecility: Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

| | | Approximete Intervel Between Onset end Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in death) a. | MYOCARDIAL INFARCTION | 1 H |
| Due to (or es e consequence of): b. | CONGESTIVE HEART FAILURE | 15Y |
| Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last — Due to (or es a consequence of): c. | DIABETES MELLITIS | 15Y |
| Due to (or es a consequence of): d. | OSTEOMYLITIS | 2M. |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: CHRONIC RENAL FAILURE; HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ M. [illegible]

29c. License number: DS2323

29d. Date signed (Month, Day, Year): 02/05/01

30. Neme end sddress of person who completed cause of death (Item 23a) (Type, Print): KHALID WASEEM 19414C LIETERSBURG PIKE D/MD21742

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
**Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

2001 04653

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DOB # 12-14-16
SS # 213-05-2070

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Kathleen Young Carmean | | | 2. DATE OF DEATH: Month Jan. Day 29, Year 2001 | 3. TIME OF DEATH: 11:-02 P.M. |
| 4. SOCIAL SECURITY NUMBER: 213-05-2070 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 14, 1916 | 8. BIRTHPLACE (State or Foreign Country): Va. |
| 9a. FACILITY NAME (If not institution, give street and number): Snow Hill Nursing Home | 9b. CITY, TOWN OR LOCATION OF DEATH: Snow Hill | 9c. COUNTY OF DEATH: Worcester | | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Worcester | 10c. CITY, TOWN OR LOCATION: Snow Hill | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 112 West Federal St. | 10f. ZIP CODE: 21863-1238 | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | | |
| 17. FATHER'S NAME (First, Middle, Last): Levin T. Young | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Miles Young | | | |
| 19a. INFORMANT'S NAME (Type/Print): Graham K. Carmean, husband | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 112 West Federal St. Snow Hill, Md. 21863-1238 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bates Memorial U.M.Church Cem. DATE: 2-1-01 | 20c. LOCATION — City or Town, State: Snow Hill, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Primary Biliary Cirrhosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Esophageal Variceal Bleed | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Ascites | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anasarca; Congestive Heart failure 2° Coronary Artery Disease, Insulin Requiring Diabetes Mellitus

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] (Sarad Barel) | 29c. LICENSE NUMBER: D 54422 | 29d. DATE SIGNED (Month, Day, Year): ▶ 1-30-01 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Suite #103; 500-Market Str.; Pocomoke; MD 21851 | | | |
| 31. DATE FILED (Month, Day, Year): FEB 01 2001 | 32. REGISTRAR'S SIGNATURE: Geneva B Sparks | | |

DHMH-18 Rev 1/89

CTB 5-2302 m 1/29/01

10 DQ

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04654

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOHN J. CAMBARDELLA SR.

2. Date of Death (Month, Day, Year): JANUARY 30, 2001

3. Time of Death: 11:40 AM

4a. Facility Name (If not institution, give street and number): 535 PRISCILLA ST

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 182-16-3056

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 7, 1917

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 535 PRISCILLA ST.

10f. Zip Code: 21804

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MERCHANDISE MANAGER

16b. Kind of Business/Industry: SEARS

17. Father's Name (First, Middle, Last): LUIGI CAMBARDELLA

18. Mother's Name (First, Middle, Maiden Surname): ANGELA AUGUSTINE

19a. Informant's Neme/Reletionship (Type, Print): SON — JOHN J. CAMBARDELLA, JR.

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code): 110 BROWN'S RUN CHURCH HILL, MD 21623

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): CAMBRIDGE CREMATORY

Date: 1/31/01

20c. Location - City or Town, Stata: CAMBRIDGE, MARYLAND

21. Signeture of Funeral Service Licensee: Robert W. Harris

22. Name end Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

**Physician /Medical Examiner**

23a. Part1. Enter tha diseese, or complicetions that caused the deeth. Do not antar tha moda of dying, such as cardiac or respiretory errest, shock, or haart failura. List only ona ceusa on aach line.

Approximata Interval Between Onset end Death

Immediata Causa (Finel disease or condition resulting in death)

a. LUNG CARCINOMA — Approximata Interval: 6 month

Due to (or es e consequence of):

Sequentielly list conditions, if eny, laading to immediata cause. Enter Underlying Ceuse (Disaase or injury thet initieted events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes casa rafarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, data and place, end due to the cause(s) and menner steted.

29b. Signature end title of certifier: Ronald P. Travitz

29c. License number: D36576

29d. Date signed (Month, Day, Year): 1/31/01

30. Neme end address of person who completed causa of daath (Item 23a) (Type, Print): RONALD P. TRAVITZ MD 560 Riverside Dr Salisbury MD 21801

SDQ

**State Registrar**

31. Date filed (Month, Dey, Year): FEB 02 2001

32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04655

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): SHIRLEY ANNE CREIGHTON
2. Date of Death (Month, Day, Year): FEBRUARY 1, 2001
3. Time of Death: 7:10 AM
4a. Facility Name (If not institution, give street and number): 7842 CROFTON DRIVE
4b. City, Town, or Location of Death: PARSONSBURG
4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 218-40-6320
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 24, 1943
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WICOMICO
10c. City, Town or Location: PARSONSBURG
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7842 CROFTON DRIVE
10f. Zip Code: 21849
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): REGISTERED NURSE
16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): ELWOOD CLARENCE BAILEY
18. Mother's Name (First, Middle, Maiden Surname): RUTH EMMA ELLIOTT

19a. Informant's Name/Relationship (Type, Print): JAMIE L. GILMORE - DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6860 WHETSTONE DRIVE HEBRON, MD 21830

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MELSON'S CEMETERY
Date: 02/03/01
20c. Location - City or Town, State: DELMAR, MARYLAND

21. Signature of Funeral Service Licensee: B. Keith Lynch, CFSP
22. Name and Address of Facility: 705 E. MAIN ST. 21804 BOUNDS FUNERAL HOME, INC. SALISBURY, MD

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Metastatic Breast Cancer — 18 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.D.
29c. License number: 030690
29d. Date signed (Month, Day, Year): FEB. 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James E. MARTIN M.D., 145 E. Carroll St., Salisbury, MD.

**State Registrar**

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

12 DQ

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04656

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Edward Coleman
2. Date of Death Month: 01 Day: 20 Year: 2001
3. Time of Death: 11:43 AM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 579-12-4470
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02 01 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Landover
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1825 Belhaven Dr. #302
10f. Zip Code: 20785
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Eduction (Specify only highest grade completed): Elementery/Secondery (0-12): 7th | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodial
16b. Kind of Business/Industry: Private
17. Father's Neme (First, Middle, Last): Charles Coleman
18. Mother's Name (First, Middle, Maiden Sumame): Martha Deale
19a. Informant's Neme/Reletionship (Type, Print): Mary J. Coleman/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1825 Belhaven Drive Landover, MD 20785
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Maryland Veterans Cemetery | Dete: 2-7-2001
20c. Location - City or Town, Stete: Cheltenham, MD
21. Signature of Funeral Service Licensee
22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert teilure. List only one cause on eech line. | Approximate Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in death): e. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last: b. CORONARY ARTERY DISEASE
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: END STAGE RENAL DISEASE

23b. Did tobacco uas contributs to the cause of death? 1 [ ] Yss 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: MD
29c. License number: D 41662
29d. Date signed (Month, Day, Year): JANUARY 21, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Saeed Kronfli MD 7610 CARROLL AVENUE, SUITE 400 - TAKOMA PARK, MD 20912

**State Registrar**

31. Dete filed (Month, Dey, Year): FEB 02 2001
32. Registrar's Signature: Geneva G. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04657

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Sharon Luvicey Cassell
2. Date of Death Month / Day / Year: JANUARY 25 2001
3. Time of Death: 5:12 PM
4a. Facility Name *(If not institution, give street and number)*: DOCTORS COMMUNITY HOSPITAL
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 579-66-9823
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 8/03/51
9. Birthplace *(State or Foreign Country)*: Wash DC

Usual Residence of Decedent

10a. Stete: MD
10b. County: Prince George's
10c. City, Town or Location: College Park
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5017 Geronimo Street
10f. Zip Code: 20740
10g. Citizen of What Country?: USA

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* Black

15. Decedent's Eduction *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Legal Secretary
16b. Kind of Business/Industry: Dow, Lohnes& Albertson Law Firm

17. Father's Neme *(First, Middle, Last)*: Andrew Rainey Cassell
18. Mother's Name *(First, Middle, Maiden Surname)*: Carrie Myers

19a. Informant's Name/Relationship *(Type, Print)*: Karla Austin/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5017 Geronimo Street College Park MD 20740

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lincoln Memorial Cemetery | Date: 2/3/01
20c. Location - City or Town, State: Suitland MD

21. Signature of Funeral Service Licensee: Joyce Montgomery-Heather
22. Neme end Address of Facility: CEDAR HILL FUNERAL HOME, INC. 4111 Pennsylvania Ave., Suitland, MD 20746

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

| | | Approximete Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in deeth) a. | Upper Gastrointestinal Bleeding | 45 minutes |
| Due to (or as a consequence of): b. | Coagulopathy and Thrombocytopenia | 2 weeks |
| Due to (or as a consequence of): c. | Metastatic Lipo Sarcoma | |
| Due to (or as a consequence of): d. | | |

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☑ No

25. Was cese referred to medicet examiner? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: Jay Zwally II
29c. License number: D0042684
29d. Date signed *(Month, Day, Year)*: 1/25/01

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Jay H. Zwally II M.D. 575 Main Street, Suite 253, Laurel, MD 20707

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signature: Sonia G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04658

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: WILLIAM SHAWN CROMER
2. Date of Death (Month, Day, Year): JANUARY 29, 2001
3. Time of Death: 1:10 A.M.
4a. Facility Name *(If not institution, give street and number)*: National Institutes of Health
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 258-31-7609
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 22 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 30, 1978
9. Birthplace *(State or Foreign Country)*: Americus, GA.

Usual Residence of Decedent

10a. State: VA.
10b. County:
10c. City, Town or Location: Norfolk
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7729 Major Ave. #C
10f. Zip Code: 23505
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4 or 5+): 1yr.
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unemployed
16b. Kind of Business/Industry: None
17. Father's Name *(First, Middle, Last)*: William Cromer
18. Mother's Name *(First, Middle, Maiden Surname)*: Maggie Wiggins
19a. Informant's Name/Relationship *(Type, Print)*: Maggie Morgan/Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 628 Winn St. Americus, Ga. 31709
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: East View Cemetery
Date: 2-3-01
20c. Location - City or Town, State: Americus, GA.
21. Signature of Funeral Service Licensee: J. P. Marshall
22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. sepsis — 24 hrs

Due to (or as a consequence of):
b. bone marrow transplant — 4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hodgkins lymphoma — 3yrs 7month

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D00 53832
29d. Date signed *(Month, Day, Year)*: 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CATHERINE A. MEITIN, MD 9000 ROCKVILLE PIKE BETHESDA, MARYLAND 20892

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No 2001 04659

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thelma Clark

2. Date of Death (Month, Day, Year): January 25, 2001

3. Time of Death: 0603

4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 214-38-0690

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feburary 17,1940

9. Birthplace (State or Foreign Country): South Carolina

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 2119 Columbia Place

10f. Zip Code: 20785

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Industrial Engineer

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Willie Matthews

18. Mother's Name (First, Middle, Maiden Surname): Cora Lee Jackson

19a. Informant's Name/Relationship (Type, Print): Patricia Clark/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6303 Patterson Street Riverdale MD 20737

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 02/01/01

20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Arteriosclerotic Hypertensive Heart Disease

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es steted. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: Salvador Sylvester DO

29c. License number: H00557927

29d. Date signed (Month, Day, Year): January 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive Cheverly, Maryland 20785

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(15)

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04660

JANUARY 25, 2001 09:48 AM

JOSEPH COPELAND Baltimore, Maryland 21215-0020

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOSEPH W COPELAND
2. Date of Death (Month, Day, Year): 01 28 2001
3. Time of Death: 09:48 AM
4a. Facility Name (If not institution, give street and number): Charlotte Hall Veterans Home
4b. City, Town, or Location of Death: Charlotte Hall
4c. County of Death: St. Mary's

**Funeral Director**

5. Social Security Number: 059 03 7298
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 16, 1918
9. Birthplace (State or Foreign Country): New York

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: [X] Yes 2 [ ] No
10e. Street and Number: 12307 Winding Lane
10f. Zip Code: 20715
10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: 37-61
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief Master Sgt.
16b. Kind of Business/Industry: United States Air Force

17. Father's Name (First, Middle, Last): Joseph Copeland
18. Mother's Name (First, Middle, Maiden Surname): Emily Kruppenbacher

19a. Informant's Name/Relationship (Type, Print): Edith V. Copeland Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12307 Winding Lane Bowie Maryland 20715

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart Church Cemetery Date: Feb. 1, 2001
20c. Location - City or Town, State: Bowie Maryland

21. Signature of Funeral Service Licensee: Michael L. Bayliss
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ABDOMINAL AORTIC ANEURYSM RUPTURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consaquence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, NIDDM, ANEMIA
DEMENTIA, GLAUCOMA, DEPRESSION
CHRONIC RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Fulton Lukban
29c. License number: 050963
29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FULTON LUKBAN MD, CHVH, CHARLOTTE HALL, MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Bernard B. Sparks

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

20

N/A

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04661

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LOUISE ALICE DORSEY

2. Date of Death (Month, Day, Year): FEBRUARY 3 2001

3. Time of Death: 8:00 PM

4a. Facility Name (If not institution, give street and number): FAHRNEY-KEEDY HOME

4b. City, Town, or Location of Death: BOONSBORO

4c. County of Death: WASHINGTON

**Funeral Director**

5. Social Security Number: 233-44-5491

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 5, 1930

9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: BOONSBORO

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 212 YOUNG AVENUE

10f. Zip Code: 21713

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEKEEPER

16b. Kind of Business/Industry: NURSING HOME

17. Father's Name (First, Middle, Last): NORMAN LEE WESTERN

18. Mother's Name (First, Middle, Maiden Surname): KATHRYN AIRY WALKER

19a. Informant's Name/Relationship (Type, Print): sharon a. reese/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 119 VALLEY VIEW COURT, BOONSBORO, MARYLAND 21713

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MOUNTAIN VIEW CEMETERY

Date: 2/6/01

20c. Location - City or Town, State: SHARPSBURG, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean

22. Name and Address of Facility: BAST FUNERAL HOME, 7606 Old National Pike, Boonsboro, Maryland 21713

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Cervical Cancer with metastases | 1 yr |
| Due to (or as a consequence of): b. | Hypertension | 10 yr |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Deep Venous Thrombosis | 1 mo |
| Due to (or as a consequence of): d. | Renal failure | 1 mo |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Gastritis, CAD, Scaroperia, Glaucoma, Metabolic Bone Disease, Hyperparathyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allen Reilly MD

29c. License number: D54749

29d. Date signed (Month, Day, Year): Feb. 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen Reilly, MD 8507 Mapleville Road, Boonsboro, Maryland 21713

**State Registrar**

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: Donna B Sparks

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ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04662

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Milton James DITLOW III

2. Date of Death: Month Feb. Day 4 Year 2001

3. Time of Death: 4:40 p.m.

4a. Facility Name (If not institution, give street and number): Avalon Manor Nursing Home

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 219-44-3342

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 12 1944

9. Birthplace (State or Foreign Country): Wash. D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 30 W. Hillcrest Road

10f. Zip Code: 21742

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1963-77

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Handyman

16b. Kind of Business/Industry: Brass Company

17. Father's Name (First, Middle, Last): Milton James Ditlow II

18. Mother's Name (First, Middle, Maiden Surname): Virginia Mae Blizzard

19a. Informant's Name/Relationship (Type, Print): Wayne L. Ditlow - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30 W. Hillcrest Road Hagerstown, Maryland 21742

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory | Date: 2/6/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Fred L. Minnich

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Ditlow, Milton

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic lung Cancer — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Obstructive lung disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

2-401 4:40 PM Time of Death

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D44996

29d. Date signed (Month, Day, Year): Feb 6, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Zafar Malik 20311 Lappans Road Boonsboro, MD 21713

**State Registrar**

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04663

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HENRY CLYDE DISHAROON SR
2. Date of Death (Month, Day, Year): January 27, 2001
3. Time of Death: 2:30 PM
4a. Facility Name (If not institution, give street and number): 109 Staton Street
4b. City, Town, or Location of Death: Fruitland
4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 219-07-2111
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 29, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Fruitland
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 109 Staton Street
10f. Zip Code: 21826
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Rural Postal Carrier
16b. Kind of Business/Industry: U.S. Postal Service

17. Father's Name (First, Middle, Last): William Henry Disharoon
18. Mother's Name (First, Middle, Maiden Surname): Dora Belle Jones

19a. Informant's Name/Relationship (Type, Print): Linda Cooper/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30931 Cooper Lane, Princess Anne, MD 21853

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St.Johns U.M. Church Cemetery
Date: 2/1/01
20c. Location - City or Town, State: Fruitland, MD

21. Signature of Funeral Service Licensee: David A. Pompa M01051
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Asystole
Due to (or as a consequence of):
b. Ischemic cardiomyopathy
Due to (or as a consequence of):
c. Atherosclerotic heart disease
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Clayton L Raab MD
29c. License number: D 19289
29d. Date signed (Month, Day, Year): 1/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Clayton L Raab MD 400 Eastern Shore Dr Salisbury MD 21801

**State Registrar**

31. Date filed (Month, Day, Year): FEB 0 1 2001
32. Registrar's Signature: Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

9+1VA DQ

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04664

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ELGIN DUNNINGTON, JR.
2. Data of Death Month Day Year: FEBRUARY 4, 2001
3. Tima of Death: 16:30
4a. Facility Nama *(If not institution, giva street and number)*: Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

**Funeral Director**

5. Social Security Number: 721-12-9699
6. Sex: 1 [X] M 2 [ ] F
7. Aga *(In yrs. last birthday)*: 76 Yrs.
If Undar 1 Yaar: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: December 20, 1924
9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedant

10a. Stata: MD
10b. County: Calvert
10c. City, Town or Location: Solomons
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 521 Swaggers Point Road
10f. Zip Code: 20688
10g. Citizan of What Country?: USA

11. Maritat Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No — If Yas, Give Yaar or Datas: WW II
13. Wes Decedant of Hispanic Origin? (Spacify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Raca - Amarican Indian, Black, Whita, etc. *Specify:* White

15. Decedant's Education *(Specify only highast grada completed)*: Elamentary/Secondary (0-12): 12; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Marine Biologist
16b. Kind of Businass/Industry: Laboratory

17. Fathar's Nama *(First, Middle, Last)*: Elgin Adams Dunnington, Sr.
18. Mothar's Nama *(First, Middla, Maidan Surname)*: Charlotte Parkman Walsh

19a. Informant's Name/Raletionship *(Type, Print)*: Ann Dunnington/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: P.O. box 523 Solomons, MD. 20688

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramovel from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Name of cematary, cramatory or othar placa)*: Old Durham Cemetery — Date: 2/8/01
20c. Location - City or Town, State: Ironsides, Maryland

21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Name and Address of Facility: BRINSFIELD-ECHOLS FUNERAL HOME, P.A. P.O. BOX 128 CHARLOTTE HALL, MD. 20622

**Physician /Medical Examiner**

23a. Part1. Entar tha diseasa, or complications that caused the daath. Do not entar the moda of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on aach lina.

Approximate Intarval Batwean Onset end Death

Immediata Causa (Final disaase or condition resulting in daath)
a. Cardiopulmonary ARREST
Dua to (or as a consequanca of):
b. Pulmonary Edema
Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequanca of):
c. Coronary Artery Disease
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes
Hypertension
Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Wara autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Wes casa referrad to medical examiner? 1 [ ] Yas 2 [X] No
26. Placa of Death *(Check only ona)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Othar: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha cause(s) and manner as statad. 2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated.
29b. Signature and title of certifier: Panwala MD
29c. Licansa number: D55027
29d. Data signad *(Month, Day, Year)*: Feb 5th 2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): DR. MANOJ PANWALA, MD PRINCE FREDERICK, MD 20678

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 07 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04665

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward Wash Davis, Sr.

2. Date of Death Month Dey Year: February 3, 2001

3. Time of Death: 09:44PM

4a Facility Name *(If not institution, give street and number)*: 10110 Marshall Corner Road

4b. City, Town, or Location of Death: White Plains

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 262-40-0697

6. Sex: 1[X] M 2[ ] F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 8,1926

9. Birthplace *(State or Foreign Country)*: Florida

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: White Plains

10d. Inside City Limits: 1[ ] Yes 2[X] No

10e. Street and Number: 10110 Marshall Corner Road

10f. Zip Code: 20695

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1[X] Yes 2[ ] No If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1[ ] Yes 2[X] No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tile Installer

16b. Kind of Business/Industry: Ceramic Tile Co.

17. Father's Name *(First, Middle, Last)*: Wil Davis

18. Mother's Name *(First, Middle, Maiden Surname)*: Jesse Catherine Howard

19a. Informant's Name/Relationship *(Type, Print)*: Eunice L. Davis Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 446, White Plains, Md. 20695

20a. Method of Disposition: 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donetion 5[ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dyal Cemetery

Date: February10,2001

20c. Location - City or Town, Stete: Raiford, Fla.

21. Signature of Funeral Service Licensee: Wesley Williams

22. Name and Address of Facility: Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 2064

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer with metatasis to Spleen

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed? 1[ ] Yes 2[X] No

24b. Were autopsy findings available prior to completion of cause of death? 1[ ] Yes 2[ ] No

25. Wes case referred to medical examiner? 1[ ] Yes 2[XXX]

26. Piece of Death *(Check only one)*

Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA

Other: 4[ ] Nursing Home 5[X] Residence 6[ ] Other *(Specify)*

27. Manner of Death: 1[XXX] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1[ ] Yes 2[ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1[XXX] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) snd menner as stated. 2[ ] **Medical Examiner:** On the basis of examinetion end/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: Krishan M. Mathur

29c. License number: D28352

29d. Date signed *(Month, Day, Year)*: February 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Krishan Mathur, MD. , P.O. Box 1703, La Plata, MD 20646

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 07 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04666

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Russell Howard Dulaney
2. Date of Death (Month, Day, Year): Jan 25, 2001
3. Time of Death: 5:18 AM
4a. Facility Name (If not institution, give street and number): Bradford Oaks Nursing Home
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 577- 09- 1945
6. Sex: 1☐M 2☐F — XX
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 20, 1914
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Brandywine
10d. Inside City Limits: 1☐Yes 2☒No — X
10e. Street and Number: 14306 Duckett Road
10f. Zip Code: 20613
10g. Citizan of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married XX Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Year or Dates: X
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐Yes 2☐No — XX — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education (Specify only highest grade completed): Elemantery/Secondary (0-12): 8th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Trucking

17. Father's Name (First, Middle, Last): Robert Henry Dulaney
18. Mother's Name (First, Middle, Maidan Surname): Imie Twyman

19a. Informant's Name/Relationship (Type, Print): Shirley A. Dulaney (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14306 Duckett Road, Brandywine, Md 20613

20a. Method of Disposition: XX Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Etlan Cemetery — Data: Jan 30, 2001
20c. Location - City or Town, State: Etlan, Virginia

21. Signature of Funeral Service Licensee: Kelli L Patton
22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Respiratory Failure — one wk
Due to (or as a consequence of):
b. Pneumonitis — one wk

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residance 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sam Tellawi
29c. License number: D34274
29d. Date signed (Month, Day, Year): 1.26.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sam Tellawi, M.D. 7700 Old Branch Ave, #B 102, Clinton, Maryland 20735

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04667

Dorothy Draper

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Dorothy Mae Draper
2. Date of Death: Month Feb Day 3 Year 2001
3. Time of Death: 2355
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 213-22-7620
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 15, 1927
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Greensboro
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12498 Kibler Road
10f. Zip Code: 21639
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Thomas Smith Bilbrough
18. Mother's Name (First, Middle, Maiden Surname): Virgie Mae Bullock

19a. Informant's Name/Relationship (Type, Print): Charles Draper spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12498 Kibler Rd Greensboro, Maryland 21639

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greensboro Cemetery
Date: Feb 7 2001
20c. Location - City or Town, State: Greensboro, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fleegle and Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT — 6 MONTHS

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D0053815
29d. Date signed (Month, Day, Year): 02/04/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Korah Pulimood MD 510 S. Fifth Ave Denton, Maryland 21629

**State Registrar**

31. Date filed (Month, Day, Year): FEB 08 2001
32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 16 Rev 6/95

ORIGINAL

CPS
01-0570-510
DUANE DOCKUS

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23 & 27 per ME G792 Certificate of Death

Reg. No. 2001 04668

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Duane Dockus

2. Date of Death (Month, Day, Year): February 2, 2001

3. Time of Death: 7:19 AM

4a. Facility Name (If not institution, give street and number): 106 South Patterson Park Ave.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 272-36-1606

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 28, 1945

9. Birthplace (State or Foreign Country): Akron, OH

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 106 South Patterson Park Ave.

10f. Zip Code: 21231

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel Worker

18b. Kind of Business/Industry: Steel Factory

17. Father's Name (First, Middle, Last): Daniel D. Dockus

18. Mother's Name (First, Middle, Maiden Surname): Ruth Bond

19a. Informant's Name/Relationship (Type, Print): Ruth Dockus - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 93 Greencrest Avenue Akron, Ohio 44312

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 2/6/01

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Helen J. Woodall

22. Name and Address of Facility: Metropolitan Funeral Service 5517 Vine Street Alexandria, VA 22310

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. DILATED CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Wes decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Dete of delivery: Month Day Year

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner M.D

29c. License number: OCME

29d. Dete signed (Month, Day, Year): February 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: Joanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0731-001
crn
Scott Bradley Davis

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED#23,27,28a-f per ME G793 031501 SS

# Certificate of Death

Reg. No. 2001 04669

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Scott Bradley Davis | February 08, 2001 | 7:20 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sacred Heart Hospital | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-86-8475 | 1☒M 2☐F | 34 Yrs. | | | 18-Aug-66 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Allegany | Frostburg | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7 1/2 South Water Street | 21532- | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | joumeyman electrician | construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| William R. Davis, Jr. | Winifred Walsh |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | |
|---|---|---|---|---|
| William R. Davis, Jr. father | 137 Washington Street | Frostburg | Maryland | 21532- |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Frostburg Memorial Park | 10-Feb-01 | Frostburg, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| John R. Durst | Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined | found: 2-8-01 | found: 6:31 AM | 1☐Yes 2☒No | unknown |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| found: apartment | 4 Powells Lane, Frostburg, MD |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature], M.D. | O.C.M.E. | February 09, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Murray G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | Geneva G. Scott |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04670

Lucille Edwards

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| | | | |
|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): Lucille Elizabeth EDWARDS | | 2. Date of Death: Month January Day 26, Year 2001 | 3. Time of Death: 9:10 p.m. |
| 4a. Facility Name (If not institution, give street and number): Williamsport Nursing Home | 4b. City, Town, or Location of Death: Williamsport | 4c. County of Death: Washington | |
| 5. Social Security Number: 214-09-8751 | 6. Sex: 1☐ M 2☒ F | 7. Age (In yrs. last birthday): 86 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.) | 8. Date of Birth (Month, Day, Year): June 2, 1914 |
| 9. Birthplace (State or Foreign Country): Maryland | | | |

Usual Residence of Decedent

| | | | |
|---|---|---|---|
| 10a. State: Maryland | 10b. County: Washington | 10c. City, Town or Location: Hagerstown | 10d. Inside City Limits: 1☐ Yes 2☒ No |
| 10e. Street and Number: 1619 Sherman Avenue | 10f. Zip Coda: 21740 | 10g. Citizan of What Country?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes: | 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: | 14. Race - Americen Indien, Bleck, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
| Elamentery/Secondery (0-12): unknown | College (1-4or 5+): unknown | sales lady | clothing |

| | |
|---|---|
| 17. Fether's Name (First, Middle, Last): Howard L. Powell | 18. Mother's Neme (First, Middle, Maidan Surneme): Louise M. Lohman |

| | | | |
|---|---|---|---|
| 19a. Informant's Name/Raletionship (Type, Print): Evelyn L. Nigh - Cousin | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda): Williamsport, Maryland 21795 | | |
| 20a. Mathod of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Steta 4☐ Donetion 5☐ Other (Specify) | 20b. Place of Disposition (Name of cemetary, crematory or other pleca): Rest Haven Cemetery | Data: Jan. 31, 2001 | 20c. Location - City or Town, State: Hagerstown, Maryland |
| 21. Signeture of Funeral Service Licensee: Fred Wistaf | 22. Name end Address of Fecility: Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 | | |

23a. Part1. Entar the diseese, or complicetions that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiretory errest, shock, or haart failura. List only one causa on aach lina.

| | | Approximeta Interval Batween Onset and Death |
|---|---|---|
| Immedlete Causa (Finel diseese or condition resulting in deeth) a. | Esophageal Cancer | months |
| Dua to (or as a consequence of): b. | Barrett's Esophagus | years |
| Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last — Due to (or es a consequence of): c. | | |
| Due to (or es a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Coronary Artery Disease, Chronic Obstructive Lung Disease, Gastritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings aveilable prior to compiation of ceuse of death? 1☐ Yes 2☐ No

25. Was case raferred to medicel examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury M | 28c. Injury et Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To tha best of my knowledge, deeth occurred et the time, date end pleca, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daeth occurred et the time, deta end place, end dua to tha causa(s) and mennar steted.

| | | |
|---|---|---|
| 29b. Signeture end title of certifier: Cynethia Kuttner-Sands, MD | 29c. Licensa number: D47451 | 29d. Dete signed (Month, Day, Year): January 27, 2001 |

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Cynthia Kuttner-Sands MD 154 N. Artizan Street, Williamsport, Maryland

**State Registrar**

| | |
|---|---|
| 31. Dete filed (Month, Day, Year): FEB 01 2001 | 32. Registar's Signetura: Donna B Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 04671

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Annie E. Essex

2. Date of Death (Month, Day, Year): February 4 2001

3. Time of Death: 17:20

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown, MD.

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 236 84 6140

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 12/22/36

9. Birthplace *(State or Foreign Country)*: WVa

Usual Residence of Decedent

10a. State: MD.

10b. County: Washington

10c. City, Town or Location: Hagerstown, MD.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: Colton Villa 750 Dual Highway

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry:

17. Father's Name *(First, Middle, Last)*: George Washington

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Tibbs

19a. Informant's Name/Relationship *(Type, Print)*: Chrystal Kemp

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 45 Charles St. Hagerstown, MD. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Pleasant View Cemetery Date: 2/8/01

20c. Location - City or Town, State: Martinsburg, WVa.

21. Signature of Funeral Service Licensee: Mary E. Watson

22. Name and Address of Facility: Watson Funeral Home 24 W. Bethel Box 856, Hagerstown, MD 21740

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia Bilateral — 48 hours.

Due to (or as a consequence of): b. Meningoma Brain

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Manzar Shafi

29c. License number: D28365

29d. Date signed *(Month, Day, Year)*: 2-4-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANZAR J. SHAFI. 268 Mill Street - Hagerstown MD.

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Amended#23am23b,30,02-13-01,dq

Reg. No. 2001 04672

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Mabel Crockett Elliott

2. Date of Death Month / Day / Year: January 31 2001

3. Time of Death: 0740

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 219-07-7499

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 3-17-1918

9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: De.

10b. County: Sussex

10c. City, Town or Location: Delmar

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: Rt. 2 Box 505

10f. Zip Code: 19940

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Seamstress

16b. Kind of Business/Industry: Men Store

17. Father's Nama *(First, Middle, Last)*: George P. Crockett

18. Mother's Name *(First, Middle, Maidan Surname)*: Florence French Crockett

19a. Informant's Name/Ralationship *(Type, Print)*: Irene E. Carey, Daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: P.O. Box 1 Fruitland, Md. 21826

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Piece of Disposition *(Nama of cematery, cramatory or other piece)*: Parsons Cemetery

Dete: 2-2-01

20c. Location - City or Town, Steta: Salisbury, Md.

21. Signature of Funaral Sarvice Licensee: Wm M. Short Jr

22. Nama and Addrass of Facility: Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940

**Physician /Medical Examiner**

23a. Part1. Entar the diseasa, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona causa on aach line.

Approximata Intarval Between Onsat and Deth: 7years

Immediata Causa (Final diseasa or condition resulting in deth)

a. Chronic Obstructive Pulmonary Disease

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Diseasa or injury that initiated avants rasulting in death) Last

b.

Due to (or as a consequence of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contributa to the causa of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings evailable prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical axaminar? 1☐ Yes 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Dey Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurrad at tha time, data and placa, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at the tima, data and placa, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: Robt A. Coker DO

29c. Licansa number: H0056197

29d. Date signed *(Month, Day, Year)*: 1/31/01

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): 100 E. Carroll St. Salisbury MD 21801 Robert A Coker, DO

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 0 1 2001

32. Registrar's Signatura: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Mabel Elliott

15 DQ

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04673

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Edith Esterman

2. Date of Death Month: February Day: 11 Year: 2001

3. Time of Death: 3:36 PM

4a. Facility Name *(If not institution, give street and number)*: The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: none

**Funeral Director**

5. Social Security Number: 012-14-5644

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 20, 1919

9. Birthplace *(State or Foreign Country)*: Poland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1121 University Blvd.,#509

10f. Zip Code: 20902

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeper

16b. Kind of Business/Industry: Accounting

17. Father's Name *(First, Middle, Last)*: Max Gerud

18. Mother's Name *(First, Middle, Maiden Surname)*: Rebecca Kleinman

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Jacobowitz - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2308 Hidden Valley Lane Silver Spring, Maryland 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Sharon Memorial Park

Date: 2/14/2001

20c. Location - City or Town, State: Sharon, Massachusetts

21. Signature of Funeral Service Licensee: Gary M. Hankin

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Inter-abdominal bleed — 8 hrs.

Due to (or as a consequence of):

b. Coagulopathy — 2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Warfarin and Lepirudin Therapy — 2 weeks

Due to (or as a consequence of):

d. Deep Venous Thrombosis — 4 months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease. Chronic renal failure. Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patrick Sosnay MD

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: Feb 11, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Patrick R. Sosnay MD 600 N Wolfe St. Baltimore MD, 21287

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 16 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04674

NAOMA FUNDERBURG 232-96-6844

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month / Day / Year) | 3. Time of Death |
|---|---|---|
| NAOMA E. FUNDERBURG | 01 / 27 / 2001 | 23:20 |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Memorial Hospital & Medical Center | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 232-96-6844 | 1☐ M 2☒ F | 96 Yrs. | | | Nov. 17,1904 | West Virginia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| WV | Mineral | Burlington | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| General Delivery | 26710 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Homemaker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Allen U. Welch | Bertha Leatherman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Frank A. Funderburg/Son | HC 72, Box 72-T New Creek, WV 26743 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Arnold Cemetery | Jan. 31 2001 | Junction, WV |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Brenda L Smith | Smith Funeral Home Rt. 2, Box 1-A Burlington, WV 26710 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive Heart Failure | 1 Year |
| Due to (or as a consequence of): | b. Coronary Artery Disease | 40 Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. | |
| Due to (or as a consequence of): | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D23167 | JANUARY 29 ,2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR JUAN ARRISUENO 902 SETON DR SUITE 205 CUMBERLAND, MD 21502

**State Registrar**

| 31. Date Filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 01 2001 | ▶ |

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04675

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Anthony Fletcher, Sr.

2. Date of Death (Month, Day, Year): Jan. 26 2001

3. Time of Death: 1:40 a.m.

4a. Facility Name (If not institution, give street and number): Joseph Richey Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 577-74-4148

8. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 46 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 1, 1954

9. Birthplace (State or Foreign Country): Wash., D.C.

Usual Residence of Decedent

10a. State: D. C.

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 774 Congress Street, S. E.

10f. Zip Code: 20032

10g. Citizen of What Country? U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [Y] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 10th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Automobile Salesperson

16b. Kind of Business/Industry: Automobile

17. Father's Name (First, Middle, Last): Cortez Fletcher, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mildred Russell

19a. Informant's Name/Relationship (Type, Print): Emily M. Fletcher (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 774 Congress St., S.E. Washington, D.C.20032

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cenetery

Date: 02-02-01

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Wanda C. Bacon CCD 361

22. Name and Address of Facility: Bacon Funeral Home, Inc. 3447 14th St., N.W. Washington, D. C. 20010

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of lung with mets — 4 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) Hospice

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: John W. Payne MD

29c. License number: D13012

29d. Date signed (Month, Day, Year): Jan 26, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John W. Payne 6565 N. Charles St 21204

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

Anthony Fletcher 1/26/01 @ 1:40 AM

(2)

| | | | |
|---|---|---|---|
| | | | |
| Cortez Fletcher, Sr. | | | Mildred Russell |
| Emily M. Fletcher | (Sister) | 774 Congress St., S.E. | Washington, D.C.20032 |
| X | | | |
| | Mt. Zion Cemetery | 02-02-01 | Baltimore, Md. |
| | Bacon Funeral Home, Inc. | 3447 14th St. N.W. | Washington, D.C. 20010 |

01-0712-021
crn
Rosalie Diane Falcon

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED# 23,27,28 per ME G793 032001 55

# Certificate of Death

Reg. No. 2001 04676

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Rosalie | Diane | Falcon | February 07, 2001 | 6:10 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 621 North Market Street | Frederick | Frederick |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 570-02-9247 | 1 M 2 X F | 44 Yrs. | | | May 05, 1956 | California |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Frederick | Frederick | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 621 North Market Street | 21701 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 X Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Waitress/Bartender | Social Club |

| 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name (First, Middle, Meiden Surneme) | | |
|---|---|---|---|---|---|
| Richard | Robert | Hall | Cecelia | Ann | Freeman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Fred Hall/Brother | 608 N Market Street, Frederick, Maryland 21701 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Smithsburg Crematory | Feb 10,2001 | Smithsburg, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Keith Lynn Robertson M00706 | Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. MIXED DRUG INTOXICATION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 X No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 No | 1 X Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 X Other (Specify) at scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 X Could not be determined | found: 2-7-01 | found: 6:00 P M | 1 Yes 2 X No | unknown |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| found at residence | 608 North Market, Fredrick, MD |

29a. Certifier (Check only one) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Dennis J. Chuteu | O.C.M.E. | February 08, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chuteu 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 16 2001 | Geneva B. Sparks |

DHMH 17 Rev 1/2001

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04677

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William Derward Growden

2. Date of Death (Month, Day, Year): January 29, 2001

3. Time of Death: 515 am

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-16-4066

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar 23, 1921

9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 444 W. 23rd Street

10f. Zip Code: 21221

10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Employee

16b. Kind of Business/Industry: Greenmount Cem

17. Father's Name (First, Middle, Last): Charles H. Growden

18. Mother's Name (First, Middle, Maiden Surname): Margaret C (Eichner)

19a. Informant's Name/Relationship (Type, Print): Leona L. Walters sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8674 G 96th Street SW; Ocala FL 34481

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rocky Gap Veterans Cem

Date: 2/02/2001

20c. Location - City or Town, State: Flintstone, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Arrest

Due to (or as a consequence of):

b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Willie Williams M.D.

29c. License number: 14585

29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Willie Williams, M.D. % Maryland General Hospital

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Sandra G Sparks

DHMH 16 Rev 6/95

ORIGINAL

William Growden

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Yes

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04678

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HELEN VIRGINIA GOCHENOUR
2. Dete of Deeth: Month Jan. Day 28 Yeer 2001
3. Time of Death: 2 35 P.M.
4a. Feclity Name (If not institution, give street end number): Fahrney-Keedy Nursing Home
4b. City, Town, or Location of Deeth: Boonsboro
4c. County of Deeth: Washington

**Funeral Director**

5. Social Security Number: 220-10-3325
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey): 82 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 6/1/1918
9. Birthplece (State or Foreign Country): VIRGINIA

**To Be Completed by Funeral Director**

Usuel Residence of Decedent

10e. State: WV
10b. County: BERKELEY
10c. City, Town or Location: MARTINSBURG
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 208 ROCK CLIFF DR.
10f. Zip Code: 25401
10g. Citizen of Whet Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Fether's Name (First, Middle, Last): CHARLES MARTIN
18. Mother's Name (First, Middle, Meiden Surneme): WILLIE LOVE CHRISMORE
19e. Informent's Neme/Reletionship (Type, Print): NANCY J. MANUEL
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 208 ROCK CLIFF DR., MARTINSBURG, WV 25401
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): ROSEDALE CEMETERY
Date: 1/31/01
20c. Location - City or Town, State: MARTINSBURG, WV
21. Signeture of Funerel Service Licensee: ▶ Charles M. Brown
22. Neme and Address of Feciity: BROWN FUNERAL HOME, 327 W. KING ST., PO BOX 821, MARTINSBURG, WV 25402

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23e. Pert I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

| | | Approximete Intervel Between Onset end Death |
|---|---|---|
| Immediate Ceuse (Finel disease or condition resulting in deeth) e. | Cerebral Vascular Accidents | 5 days |
| Due to (or es e consequence of): b. | END Stage Dementia Cortical | 10 years |
| Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest — Due to (or es e consequence of): c. | Hypertension | 30 years |
| Due to (or es e consequence of): d. | Chronic Obstructive Pulmonary Disease | 30 yeAes. |

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: h/o CVA, PARKINSON, Osteoporosis, Coronary Artery Disease.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one): 1☐ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signeture and title of certifier: ▶ Allen Reilly MD
29c. License number: D54749
29d. Dete signed (Month, Dey, Yeer): JAN 29 2001
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): 8507 Mapleville Road, Boonsboro, MD. 21713-1844

**State Registrar**

31. Dete filed (Month, Dey, Yeer): FEB 01 2001
32. Registrer's Signeture: Joanne B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Helen Virginia Gochenour
Baltimore, Maryland 21215-0020

Helen Virginia Gochenour
Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04679

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Edith Gibson

2. Data of Death (Month, Day, Yaar): January 23, 2001

3. Tima of Death: 23:23 PM

4a Facility Nama *(If not institution, giva street and number)*: Prince Georges Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 219-48-6382

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 51 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 03-16-1949

9. Birthplace *(State or Foraign Country)*: Maryland

Usual Rasidence of Dacedant

10a. Stata: MD

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 7201 Fast Ridge Dr

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Navar Married 2☒ Married 3☐ Widowad 4☐ Divorced

12. Wes Decedent Ever in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Giva Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxicen, Puarto Ricen, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indien, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): 12th; Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Baker

16b. Kind of Businass/Industry: Private

17. Fathar's Nama *(First, Middla, Last)*: Charles Brandford

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Elsie Duckett

19a. Informant's Name/Ralationship *(Type, Print)*: Emory E. Gibson/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 7201 Fast Ridge Dr Landover, MD 20785

20a. Method of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Harmony Cemetery

Date: 02-1-01

20c. Location - City or Town, Stete: Landover, MD

21. Signatura of Funeral Service Licensee

22. Nama end Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the diseasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only ona cause on each line.

Approximate Intarval Between Onset and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)

e. Hemopericardium

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata ceuse. Entar Undarlying Cause (Disaase or injury that initiated evants rasulting in death) Last

b. Dissecting Thoracic Aortic Aneurysm

Dua to (or as a consequance of):

c.

Due to (or es e consequance of):

d.

Part II. **Other signficant conditions** contributing to death but not resulting in the undarlying causa givan in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy parformed? 1☑ Yes 2☐ No

24b. Wera autopsy findings available prior to completion of cause of daath? 1☑ Yes 2☐ No

25. Was cesa ratarred to medical examinar? 1☒ Yas 2☐ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Daath: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigetion 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Piece of Injury - At homa, tarm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha ceuse(s) and mannar stated.

29b. Signatura and titla of certifiar: J. M. [illegible] for

29c. Licansa number: OCME

29d. Date signed *(Month, Day, Year)*: JANUARY 30, 2001

30. Nama end eddrass of parson who complated ceusa of daath (Item 23a) (Type, Print): M. Korell, M.D. 111 PENN ST. BALTO MD 21201

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760,**

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

2001 04680

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Steven Alphonso Gaston
2. DATE OF DEATH (Month, Day, Year): 01 23 01
3. TIME OF DEATH: 9:15 PM M
4. SOCIAL SECURITY NUMBER: 250-03-7911
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 38 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): July 18, 1962
8. BIRTHPLACE (State or Foreign Country): Washington DC
9a. FACILITY NAME (If not institution, give street and number): 6903 Hawthorne Street
9b. CITY, TOWN OR LOCATION OF DEATH: Landover
9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George
10c. CITY, TOWN OR LOCATION: Landover
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 6903 Hawthorne Street
10f. ZIP CODE: 20785
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [XX] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [XX] NO IF YES, GIVE WAR OR DATES: NO
13. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: XX
14. RACE — Americen Indien, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): None (Disabled) College (1-4 or 5 +):
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Never Worked
16b. KIND OF BUSINESS/INDUSTRY: None
17. FATHER'S NAME (First, Middle, Last): Billy James Gaston
18. MOTHER'S NAME (First, Middle, Meiden Surname): Ina J. Taylor
19a. INFORMANT'S NAME (Type/Print): Ina J. Gaston
19b. MAILING AOORESS (Street end Number or Rural Route Number, City or Town, State, Zip Code): 6903 Hawthorne St., Landover MD 20785
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, cremetory or other piece): Glenwood DATE: 01/29/01
20c. LOCATION — City or Town, State: Washington DC
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F Baker
22. NAME ANO ADDRESS OF FACILITY: Robert G. Mason Funeral 1661 Good Hope Rd SE, Wash DC 20020

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia — 3 days

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Progressive Dementia Malnourished — 39 yrs

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATN (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Nome 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Nomicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner ee stated.
2 [ ] MEOICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, desth occured at the time, date end piece, end due to the ceuse(s) end menner ee stated.

29b. SIGNATURE ANO TITLE OF CERTIFIER: Gary W. Jones
29c. LICENSE NUMBER: D30111
29d. DATE SIGNED (Month, Day, Year): Jan. 24, 2001

30. NAME ANO ADDRESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print): GARY W. JONES P.O BOX 1464 Laurel Md. 20725

31. DATE FILED (Month, Day, Year): JAN 31 2001
32. REGISTRAR'S SIGNATURE: Brenda G. Sparks

DHMH-16 Rev 1/89

01-0455-033
DARNELL GLENN
ASP

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04681

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Darnell Lamont Glenn
2. Date of Death — Month: JANUARY Day: 27 Year: 2001
3. Time of Death: 0233
4a. Facility Name *(If not institution, give street and number)*: PRINCE GEORGES HOSPITAL
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

**Funeral Director**

5. Social Security Number: 579-02-1383
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 20 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 14, 1980
9. Birthplace *(State or Foreign Country)*: Wash., D.C.

Usual Residence of Decedent

10a. State: District of Columbia
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4477 B St., S.E. #302
10f. Zip Code: 20019
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Unemployed
16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: Vincent Anthony
18. Mother's Name *(First, Middle, Maiden Surname)*: Jacqueline Glenn

19a. Interment's Name/Relationship *(Type, Print)*: Jacqueline Anthony - Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4477 B St., S.E. #302, Wash., D.C. 20019

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery — Date: 2/3/2001
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: John T. Stewart, III
22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., D.C. 20019

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. GUNSHOT Wounds TO BACK of CHEST
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 1/27/01
28b. Time of Injury: 1:45 A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: SUBJECT WAS SHOT
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: APARTMENT Building
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 108 ATLANTIC STREET WASHINGTON, D.C.

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29b. Signature and title of certifier: J. M. Titus
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: JANUARY 27, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 31 2001
32. Registrar's Signature: pending D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04682

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Loretta Arlene Gutrick

2. Date of Death (Month, Day, Year): JANUARY 29 2001

3. Time of Death: 12:10 AM

4a. Facility Name (If not institution, give street and number): Doctor's Hospital

4b. City, Town, or Location of Death: Lanham, MD

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 227-54-2431

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-28-1939

9. Birthplece (State or Foreign Country): Glenallen, VA

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9214 Rolling View Drive

10f. Zip Code: 20706

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U,S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yea or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yea 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service Manager

16b. Kind of Business/Industry: Government

17. Fathar's Neme (First, Middle, Last): Warren Coles

18. Mother's Name (First, Middle, Maiden Surnama): Greta Witcher

19a. Informent's Name/Reletionship (Type, Print): Theodore Gutrick/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9214 Rolling View Drive Lanham, MD 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramovai from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park

Date: 2-2-01

20c. Location - City or Town, Stete: Landover, MD

21. Signature of Funeral Service Licensee

22. Name end Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cauae on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death) e. Metastatic Rectal Cancer — 6 months

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to complation of causa of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: MD

29c. Licansa number: D81715

29d. Date signed (Month, Day, Year): 1-30-01

30. Neme and addreaa of person who completed cause of deth (Item 23a) (Type, Print): CHITRA VENKATARAMAN MD 6201 GREENBELT ROAD U#3 COLLEGE PARK MD 20740

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GUTRICK, LORETTA

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

6

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04683

**Physician /Medical Examiner**

1. Decedent's Nema *(First, Middle, Last)*: CHARLES WILLIAM HARTMAN
2. Dete of Deeth: Month JANUARY Dey 31 Year 2001
3. Time of Death: 1:32 PM
4e. Facility Neme *(If not institution, giva street end number)*: Sacred Heart Hospital
4b. City, Town, or Location of Deeth: Cumberland
4c. County of Deeth: Allegany

**Funeral Director**

5. Social Security Number: 216 40 3273
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 57 Yrs. | If Under 1 Year: Months | Deys | If Under 24 Hrs.: Hours | Min.
8. Dete of Birth *(Month, Dey, Year)*: 9-24-1943
9. Birthplece *(Stete or Foreign Country)*: WV

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 205 Baltimore Avenue
10f. Zip Code: 21502
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐Nevar Married 2☐Merried 3☐Widowed 4☒Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yaar or Datas: 60-73
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Race - Americen Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Computer Operator
16b. Kind of Business/Industry: Legal/financial

17. Fathar's Nema *(First, Middle, Last)*: William Richard Hartman
18. Mother's Neme *(First, Middle, Maidan Surnama)*: Willa Ruth Watts

19e. Informent's Neme/Reletionship *(Type, Print)*: Jo Ellen Troutman, sister
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Steta, Zip Code)*: P. O. Box 13, Wellersburg, PA 15564

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from Stete 4☐Donetion 5☐Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: The Cumberland Crematory
Dete: 2-1-01
20c. Location - City or Town, Stete: Cumberland, MD

21. Signature of Funeral Service Licensee: ▶ Harvey H Zeigler
22. Neme end Address of Facility: Harvey H. Zeigler Funeral Home, Hyndman, PA

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset end Death |
|---|---|---|
| Immediate Ceuse (Finel disaase or condition rasulting in death) a. | Sepsis syndrome | 10 days |
| Due to (or es a consequence of): b. | Pneumonia | 15 days |
| Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last. Due to (or es a consequence of): c. | | |
| Due to (or es a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alcoholism, chronic obstructive pulmonary disease, malnutrition, encephalopathy

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☑No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐Yes 2☑No

25. Wes case referred to medical examiner? 1☐Yes 2☑No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Death: 1☑Naturel 2☐Accident 3☐Suicida 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Locetion *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2☐**Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end manner steted.

29b. Signeture end title of certifier: ▶ Husam Semaan, M.D.
29c. License number: D0052207
29d. Date signed *(Month, Dey, Year)*: January 31, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): HUSAM SEMAAN, SACRED HEART HOSPITAL, CUMBERLAND MD 21502

**State Registrar**

31. Dafa filed *(Month, Dey, Year)*: FEB 02 2001
32. Registrar's Signeture: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

4

MD

Amended #10c, nls, 2/6/01, Allegany Co.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No 2001 04684

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: LOIS VIRGINIA HOWELL
2. Date of Death: Month FEB Day 3 Year 2001
3. Time of Death: 9:50 PM
4a. Facility Name *(If not institution, give street and number)*: CUMBERLAND NURSING HOME
4b. City, Town, or Location of Daath: CUMBERLAND
4c. County of Death: ALLEGANY

**Funeral Director**

5. Social Security Number: 213-22-3709
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB 2,1913
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: ~~CUMBERLASND~~ CUMBERLAND
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: ROUTE 1 BOX 174,MT. SAVAGE RD.
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: WILLIAM EDWARD DURST
18. Mother's Name *(First, Middle, Maiden Surname)*: CORDELIA ELLEN BLOCHER

19e. Informant's Name/Relationship *(Type, Print)*: WAYNE HOWELL-SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 21 ARCH ST., CUMBERLAND, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: REST LAWN MEMORIAL GARDENS — Date: FEB 7,2001
20c. Location - City or Town, State: LAVALE, MD

21. Signature of Funeral Service Licensee: Douglas S Hafer
22. Nama and Addrass of Facility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Intervel Between Onsat and Death

Immediate Ceuse (Fınal disease or condition resulting in deeth)
e. Urosepsis — 4days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Rectovaginal fistula

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straet, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner steted.
29b. Signature and title of certifier
29c. License number: D0033280
29d. Date signed *(Month, Day, Year)*: Feb 5, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): DR. S. GUPTA, 625 KENT AVE., CUMBERLAND, MD 21502

**State Registrar**

31. Date filed *(Month, Dey, Year)*: FEB 0 6 2001
32. Registrar's Signatura

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

YHS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04685

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Curtis D. House, Sr.
2. Date of Death (Month, Day, Year): February 05, 2001
3. Time of Death: 07:00 AM
4a. Facility Name *(If not institution, give street and number)*: 4 Powell's Lane, Apt. B-8
4b. City, Town, or Location of Death: Frostburg
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 215-20-5776
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 15-May-26
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4 Powell's Lane Apt. B-8
10f. Zip Code: 21532-
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Yeer or Detes: Korean Conflict
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: laborer
16b. Kind of Business/Industry: manufacturing

17. Father's Name *(First, Middle, Last)*: Joseph House
18. Mother's Name *(First, Middle, Maiden Surneme)*: Madge Cook

19a. Informent's Name/Relationship *(Type, Print)*: Betty Hunter Sister
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 161 Warns Lane Frostburg Maryland 21532-

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Frostburg Memorial Park — Date: 07-Feb-01
20c. Location - City or Town, State: Frostburg, Maryland

21. Signature of Funeral Service Licensee: John R. Durst
22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth): e. CHRONIC OBSTRUCTIVE LUNG DISEASE — 5 YRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 ☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Robustiano J. Barrera Jr.
29c. License number: D-14865
29d. Date signed *(Month, Dey, Year)*: JAN. 6, 2001

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Robustiano J. Barrera, M.D., Memorial Hospital Medical Building, Cumberland, Maryland 21502

**State Registrar**

31. Date filed *(Month, Dey, Year)*: FEB 06 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

4

YDS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04686

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Aumilda Alice HOLLAND
2. Date of Death (Month, Day, Year): January 27, 2001
3. Time of Death: 5:35 a.m.
4a. Facility Name *(If not Institution, give street and number)*: Williamsport Retirement Village
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 457-66-7121
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb.14,1914
9. Birthplace *(State or Foreign Country)*: Texas

Usual Residance of Decedent

10a. Stata: W. VA.
10b. County: Jefferson
10c. City, Town or Locaiion: Shepherdstown
10d. Insida City Limits: 1☒Yes 2☐ No
10e. Street and Number: Route 1, Box 131-17
10f. Zip Coda: 25443
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U,S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Wes Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indien, Black, Whita, atc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12; Collega (1-4or 5+): 1
16a. Decedant's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: beautician
16b. Kind of Businass/Industry: beauty shop

17. Father's Nama *(First, Middle, Last)*: Charles Oscar Wilkerson
18. Mothar's Nama *(First, Middle, Maiden Surname)*: Blanche Augusta Kennedy

19a. Informant's Name/Raletionship *(Type, Print)*: Kay Williams - daughter
19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Route 1, Box 131-17, Shepherdstown, W. Va. 25443

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Mt. Park Cemetery
Data: 2-2-01
20c. Location - City or Town, Stata: Saint Jo, Texas

21. Signature of ~~Funeral Service~~ Licensee: Scott Minnich
22. Name end Address of Facility: MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart tailure. List only ona causa on aach lina. — Approximata Interval Between Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death)
a. urosepsis — days
Dua to (or as e consequanca of):
b. end-stage dementia — months
Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. cerebrovascular accidents — years
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.: hypertension

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to complation of causa of death? 1☐ Yas 2☐ No

25. Was casa raferred to medical examinar? 1☐ Yas 2☒ No
26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and placa, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to tha cause(s) and mannar stated.

29b. Signatura end titla of certifiar: Cynthia Kuttner-Sands, MD
29c. Licansa number: D47451
29d. Date signed *(Month, Day, Year)*: January 27, 2001

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Cynthia Kuttner-Sands,MD, 154 N. Artizan Street, Williamsport, Maryland 21795

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No 2001 04687

VERGIE ARZOLLA HURD

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: VERGIE ARZOLLA HURD
2. Data of Daath — Month: Feb. Day: 1, Yaar: 2001
3. Tima of Daath: 5:40PM
4a. Facility Nama *(If not institution, giva street and numbar)*: Fahrney-Keedy Nursing Home
4b. City, Town, or Location of Death: Boonsboro
4c. County of Daath: Washington

**Funeral Director**

5. Social Sacurity Number: 214-74-8307
6. Sex: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: Aug. 9, 1905
9. Birthplaca *(Stata or Foraign Country)*: Maryland

**To Be Completed by Funeral Director**

Usual Rasidanca of Decedant

10a. Stata: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Straat and Number: 19804 Marvin Avenue
10f. Zip Coda: 21742
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowad 4☐ Divorcad
12. Was Dacadant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Spacify:*
14. Raca - Amarican Indian, Black, Whita, atc. *Specify:* white

15. Decadant's Education *(Spacify only highast grada complatad)*: Elamantary/Secondary (0-12): 0-6 — Collaga (1-4or 5+): 0
16a. Decadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: homemaker
16b. Kind of Businass/Industry: her own

17. Fathar's Nama *(First, Middla, Last)*: unknown
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: unknown

19a. Informant's Nama/Ralationship *(Typa, Print)*: Marvin Hurd - son
19b. Mailing Addrass *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 19808 Marvin Avenue, Hagerstown, Maryland 21742

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*
20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Smithsburg Cemetery — Data: Feb. 5/01
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signatura of Funaral Service Licansaa: James R. Spicer
22. Nama and Addrass of Facility: Minnich Funeral Home, 415 East Wilson Blvd., Hagerstown, Maryland 21740

**Physician /Medical Examiner**

23a. Part I. Entar tha disaasa, or complications that causad the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

| | | Approximata Intarval Batwaan Onsat and Death |
|---|---|---|
| Immadiata Causa (Final disaasa or condition rasulting in daath) a. | END STAGE DEMENTIA | 10 yrs |
| Dua to (or as a consaquanca of): b. | Hypertension | 20 yrs |
| Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last — Dua to (or as a consaquanca of): c. | Diabetes Mellitus | 20 yrs |
| Dua to (or as a consaquanca of): d. | Arteriosclerotic Cardio Vascular Ds | 30 yrs |

Part II. **Othar significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.: Metabolic Bone Disease, Failure to Thrive, Osteoporosis, Advance Sarcopenia, Immobility Synd.

23b. Did tobacco usa contributa to tha cauaa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to compliation of cause of daath? 1☐ Yas 2☒ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was casa rafarrad to madical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Chack only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Spacify)*

27. Manner of Daath: 1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*
28f. Location *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only ona)*: 1☒ **Cartifying Physician**: To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.

29b. Signatura and Titla of Cartifiar: Allen Reilly MD
29c. Licansa number: D54749
29d. Data signad *(Month, Day, Yaar)*: Feb 1, 2001

30. Nama and addrass of parsan who complatad causa of daath (Itam 23a) (Typa, Print): 8507 Mapleville Road, Boonsboro, MD 21713-1844

**State Registrar**

31. Data filad *(Month, Day, Yaar)*: FEB 06 2001
32. Ragistrar's Signatura: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

DHMH 16 Rev 6/95

Amended
Item #5./WCHD/SC
2-7-01

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04688

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jessie Marie HOWELL

2. Data of Death: Month: February Day: 2 Year: 2001

3. Time of Death: 13:42

4a. Facility Name (If not Institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 217-56-1659 ~~220-28-3273~~

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 24 1905

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: Route 4

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Her own home

17. Father's Name (First, Middle, Last): Thomas Painter

18. Mother's Name (First, Middle, Maiden Surname): Annie Longerbeam

19a. Informant's Name/Relationship (Type, Print): Ann Wolfe - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12311 Pleasant Walk Road Myersville, Md. 21773

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Fairview Cemetery

Data: 2/6/01

20c. Location - City or Town, State: Keedysville, Maryland

21. Signature of Funeral Service Licensee: Fred L Vestal

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

**Physician /Medical Examiner**

23a. Part1. Enter the diseesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceusa on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — 5 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PROBABLE SEPSIS — 24 hours.

Due to (or as a consequence of):

c. PNEUMONIA — 5 DAYS.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Maureen Smith

29c. License number: D28365

29d. Date signed (Month, Day, Year): 2-3-01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAUREEN J. SMITH. 368 Mill Street Hagerstown MD 21740

**State Registrar**

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Howell, Jesse M.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 04689

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Catharine Howland
2. Date of Death: Month: January Day: 31 Year: 2001
3. Time of Death: 8:05 p.m.
4a. Facility Name (If not institution, give street and number): Wicomico Nursing Home
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 716-18-1624
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUGUST 28, 1916
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4940 CARDINAL DRIVE
10f. Zip Code: 21804
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): ROBERT C. SMITH
18. Mother's Name (First, Middle, Maiden Surname): CATHARINE CLINE

19a. Informant's Name/Relationship (Type, Print): HARRIET H. STAMBACK - DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4940 CARDINAL DR. SALISBURY, MD 21804

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CAMBRIDGE CREMATORY
Date: 2/1/01
20c. Location - City or Town, State: CAMBRIDGE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ B. Keith Lynn CFP
22. Name and Address of Facility: BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Scott Rifkin MD
29c. License number: D34145
29d. Date signed (Month, Day, Year): 02/02/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Rifkin 11 Aston Ct Owings Mills, MD 21117

**State Registrar**

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Catharine Howland

5 DQ

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04690

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret Helen Howell

2. Data of Death Month Day Yaar: Jan 24, 2001

3. Time of Death: 5:00 A.M.

4a Facility Nama (If not institution, giva street and number): 8105 Poplar Hill Drive

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 577 18 2888

6. Sax: 1☐ M 2☒ F XX

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Sept 30, 1909

9. Birthplace (Stata or Foreign Country): Tenn

Usual Residance of Decedant

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1☐ Yas 2☒ No X

10e. Street and Number: 8105 Poplar Hill Drive

10f. Zip Code: 20735

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced XX

12. Was Decedant Evar in U,S. Armed Forcas? 1☐ Yas 2☒ No XX If Yas, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No XX Specify:

14. Race - American Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): 12; Collega (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Name (First, Middla, Last): Charles E. Shepherd

18. Mothar's Nama (First, Middla, Maiden Surneme): Mary E. Kreitzer

19a. Informant's Neme/Ralationship (Type, Print): Shirley E. Sweet (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 8105 Poplar Hill Drive, Clinton, MD 20735

20a. Method of Disposition: XX 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cemafery, crametory or othar place): Cedar Hill Cemetery

Date: Jan 29, 2001

20c. Location - City or Town, Stete: Suitland, Maryland

21. Signature of Funaral Service Licensee: [signature]

22. Nama and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disaasa, or complications that causad the deeth. Do not antar tha moda of dying, such as cardiac or respiratory errest, shock, or haart failura. List only one causa on aach line.

Approximata Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in daath)

e. COPD

Due to (or es e consequence of):

Sequantially list conditions, if any, leeding to immediata ceusa. Entar Underlying Ceusa (Disaasa or injury that initiated avents rasulting in death) Last

b. Pulmonary fibrosis

Dua to (or as e consequance of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceusa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown XX

24a. Was an autopsy parformed? 1☐ Yas 2☒ No X

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No N/A

25. Was case rafarred to medical examinar? 1☐ Yas 2☒ No XX

26. Place of Deeth (Check only ona)

Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Homa 5☒ Rasidance X 6☐ Other (Specify)

27. Mennar of Death: 1☒ Natural XX 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29a. Certifiar (Check only one) XX 1☒ **Certifying Physician**: To the bast of my knowledga, daath occurred at tha tima, data and place, and due to the ceuse(s) and mannar es stated.

2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, date end place, end dua to the cause(s) and mannar stated.

29b. Signatura and tita of certifier: Mahin Yazdani MD

29c. Licansa number: D17774

29d. Data signed (Month, Day, Year): 01/25/01

30. Nama and address of parson who completed cause of daath (Item 23a) (Typa, Print): Mahin Yazdani 2555 Solomons Is. Rd Huntingtown, MD 20639

**State Registrar**

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04691

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): Gertrude Emily Heckman
2. Date of Deeth Month Day Yeer: 01- 31- 2001
3. Time of Deeth: 1:30Am
4e. Facility Neme (If not institution, give street end number): Villa Rosa Nursing Home
4b. City, Town, or Location of Deeth: Mitchellville
4c. County of Deeth: Prince George's

**Funeral Director**

5. Social Security Number: 183-58-2642
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Jan 29, 1923
9. Birthplace (Stete or Foreign Country): Pennsylvania

Usuei Residence of Decedent

10a. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: College Park
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 9728 51st Place
10f. Zip Code: 20740
10g. Citizen of Whet Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Eduestion (Specify only highest grede completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Fether's Name (First, Middle, Last): Meade Kerr
18. Mother's Neme (First, Middle, Maiden Surneme): Mildred Klingensmith
19e. Informent's Name/Relationship (Type, Print): Richard L. Heckman - Son
19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 9728 51st Place College Park, Maryland 20740
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Metropolitan Crematory
Date: 1/31/2001
20c. Location - City or Town, Stete: Alexandria, Virginia
21. Signature of Funeral Service Licensee: Henry L. Fox
22. Name end Address of Feeility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

**Physician /Medical Examiner**

23a. Pert I. Enter the disease, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Intervei Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death):
e. Acute myocardial infarction — a few hours

Due to (or es e consequence of):
b. Atherosclerotic heart disease

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Lest:
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part ii. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.
Chronic obstructive pulmonary disease, Senile dementia with agitated features

23b. Did tobacco uee coptribute to the ceuse of deeth? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☑ No
26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Deeth: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Exeminer:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: Peter M Schissler MD
29c. License number: D22780
29d. Date signed (Month, Dey, Year): January 31, 2001
30. Neme and eddress of person who completed ceuse of deeth (item 23e) (Type, Print): Peter M Schissler MD 7500 Greenway Ctr Dr. Greenbelt MD 20770

**State Registrar**

31. Date filed (Month, Day, Yeer): JAN 31 2001
32. Registrar's Signeture: G. Sparks

DHMH 16 Rev 6/95

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mentel Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04692

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Geraldine A. Hochrein

2. Date of Death: Month: January; Day: 28; Year: 2001

3. Time of Death: 11:15 PM

4a. Facility Name (If not institution, give street and number): Crofton Convalescent Center

4b. City, Town, or Location of Death: Crofton

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 217 58 6359

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 16, 1909

9. Birthplace (State or Foreign Country): Baltimore MD

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8415 Bellona Lane

10f. Zip Code: 21204

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4 or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles F. Mutter

18. Mother's Name (First, Middle, Maiden Surname): Anna M. Remke

19a. Informant's Name/Relationship (Type, Print): Elizabeth A. Mishev Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3611 Majestic Lane Bowie Maryland 20715

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cemetery

Date: February 1, 2001

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: ▶ Robert E. Evans

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Dehydration — 7d

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Cerebrovascular Accident — 10 years

Due to (or as a consequence of):

c. Dysphagia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Howard K Schultz

29c. License number: D35848

29d. Date signed (Month, Day, Year): Jan 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard K Schultz DO 1438 Defense Hwy Gambrills MD 21054

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

(4)

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04693

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Babe Elmont Johnson

2. Data of Death — Month: February Day: 1 Year: 2001

3. Time of Death: 0001

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 214-28-2242

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): April 29, 1921

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 720 Interval Road

10f. Zip Code: 21742

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1947

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Charles Edward Johnson Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mamie Alice Reed

19a. Informant's Name/Relationship (Type, Print): Sylvia A. Johnson Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 720 Interval Road, Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park

Date: 02-05-2001

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: R. Neal Brady

22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, hagerstown, Md. 21740

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive pulmonary disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D21457

29d. Date signed (Month, Day, Year): 2-1-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABDUL WAHEED MD - 1282 - OAKHILL AVE. HAGERSTOWN MD 21742

**State Registrar**

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04694

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Maryellen B. Johnson

2. Date of Death Month Day Year: February 1, 2001

3. Time of Death: 7:55 PM

4a. Facility Name *(If not institution, give street and number)*: 12106 Sondberg Lane

4b. City, Town, or Location of Death: Mitchellville

4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 577-54-4104

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr. 16, 1941

9. Birthplace *(State or Foreign Country)*: Wash.D.C.

Usual Residence of Decedent

10a. State: Md.

10b. County: Prince Georges

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12106 Sondberg Lane

10f. Zip Code: 20721

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Daycare teacher

16b. Kind of Business/Industry: Pre School Nursery

17. Father's Name *(First, Middle, Last)*: Chris Sondberg

18. Mother's Name *(First, Middle, Maiden Surname)*: Nellie Oleary

19a. Informant's Name/Relationship *(Type, Print)*: Edward R. Johnson husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12106 Sondberg Lane, Mitchellville, Md. 20721

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery

Date: 02-05-01

20c. Location - City or Town, State: Brentwood, Md.

21. Signature of Funeral Service Licensee: ▶ Robert J. Beall

22. Name and Address of Facility: Beall Funeral Home, 6512 N.W. Crain Hwy., Bowie, Md. 20715

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic ovarian carcinoma — 7 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☒ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M Will MD

29c. License number: D35176

29d. Date signed *(Month, Day, Year)*: 02/02/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marcia Will MD , 7525 Greenway Ctr. Drive, Greenbelt, Md. 20770

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No 2001 04695

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LEWIS D. JOHNSON
2. Date of Death (Month, Day, Year): January 25,2001
3. Time of Death: 9:25 A.M.
4a. Facility Name (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 237-62-0641
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.18,1939
9. Birthplace (State or Foreign Country): Leesburg, N.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Oxon Hill
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1904 Deerfield Court
10f. Zip Code: 20745
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Porter
16b. Kind of Business/Industry: Giant Food
17. Father's Name (First, Middle, Last): Sylvester Johnson
18. Mother's Name (First, Middle, Maiden Surname): Mary M. Lea
19a. Informant's Name/Relationship (Type, Print): Norma Johnson/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1904 Deerfield Court Oxon Hill, Md. 20745
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Church Cemetery
Date: 1/30/2001
20c. Location - City or Town, State: Person County, N.C.
21. Signature of Funeral Service Licensee: W. J. Jeffers
22. Name and Address of Facility: Frazier's Funeral Home, Inc. 389 R.I. Ave., N.W. Wash.,DC 20001

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Mycloma — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.A. Meelu MD
29c. License number: D 46246
29d. Date signed (Month, Day, Year): January 25, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M.A. Meelu Waldorf, Md.

**State Registrar**

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Bernice G. Sparks

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04696

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: James Johnson
2. Date of Death Month Day Year: January 27, 2001
3. Time of Death: 5:41 AM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 577-56-8278
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 58 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 13, 1942
9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: DC
10b. County:
10c. City, Town or Location: Washington DC
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2007 Maryland Avenue, N.E. #8
10f. Zip Code: 20002
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: John Johnson
18. Mother's Name *(First, Middle, Maiden Surname)*: Rosa Gardner

19a. Informant's Name/Relationship *(Type, Print)*: Rosemary Willis/Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6307 Hilmar Drive #12, Forestville, MD 20747

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Mt. Olivet Cemetery
Date: 2/3/01
20c. Location - City or Town, State: Washington DC

21. Signature of Funeral Service Licensee: Janice Edwards
22. Name and Address of Facility: Hodges & Edwards Funeral Home, 3910 Silver Hill Road, Suitland, MD 20746

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Septic schock | |
| | Due to (or as a consequance of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. ischemic bowel disease | 6 day |
| | Due to (or as a consequence of): | |
| | c. aortic occlusion | 6 day |
| | Due to (or as a consequance of): | |
| | d. end stage renal disease | 6 days |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kaldun Nossuli MD
29c. License number: D23091
29d. Data signed *(Month, Day, Year)*: 01/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kaldun Nossuli, 4915 Auburn Avenue Bethesda MD 20814

**State Registrar**

31. Data filed *(Month, Day, Year)*: JAN 30 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04697

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Norman Jennings, Sr.

2. Date of Death (Month, Day, Year): JANUARY 28, 2001

3. Time of Death: 03:33 A.M.

4a. Facility Name (If not institution, give street and number): MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death: CAMP SPRINGS

4c. County of Death: PRINCE GEORGE'S

**Funeral Director**

5. Social Security Number: 213-32-2931

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 20, 1933

9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: District Heights

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2132 County Road, #104

10f. Zip Code: 20747

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Norman Jennings

18. Mother's Name (First, Middle, Maiden Surname): Cora Grant

19a. Informant's Name/Relationship (Type, Print): Dorothy C. Jennings - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2132 County Rd., #104, District Heights, MD 20747

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cem. Union Grove AME Zion Ch. | Date: 2/3/2001

20c. Location - City or Town, State: Bear Creek, N.C.

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., D.C. 20019

NAME: NORMAN JENNINGS

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. END STAGE PROSTATE CANCER — UNKNOWN

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: AFE 54682

29d. Date signed (Month, Day, Year): JANUARY 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KENNETH E. ROBINSON, MAJ, USAF, MC — 89 MDG/1050 W. PERIMETER RD. ANDREWS AIR FORCE BASE, MD 20762-6600

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760,**

**State Registrar**

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: pending B. Sparks

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04698

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Douglas Allen Jones
2. Date of Death: Month 01 Day 30 Year 2001
3. Time of Death: 12:35 AM
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 298-58-1799
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 41 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 08-26-1959
9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: DC
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6512 North Capital Street, N.W.
10f. Zip Code: 20012
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Unk
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter
16b. Kind of Business/Industry: Veteran Administration

17. Father's Name *(First, Middle, Last)*: Richard Lee Jones
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Louise Lang

19a. Interment's Name/Relationship *(Type, Print)*: Richard L. Jones/ Father
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2502 Amherst Road; Adelphi, Maryland 20783

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Northern Virginia Crematory
Date: 2/1/01
20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: Wanda C. Bacon CC0361
22. Name and Address of Facility: Bacon Funeral Home, Inc. 3447 14th Street, NW Washington, DC 20010

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sarcoidosis with Central Nervous System
Due to (or as a consequence of): manifestations — 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Paul A. DeVore MD
29c. License number: D01852
29d. Date signed *(Month, Day, Year)*: January 30, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul A. DeVore MD 4203 Queensbury Rd Hyattsville MD 20781

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Baltimore, Maryland 21215-0020. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

(3)

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04699

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Richard James

2. Date of Death: Month 1 Day 27 Year 01

3. Time of Death: 12:45 PM

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 217-09-4784

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 1, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedant

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4305 Canyonview Dr.

10f. Zip Code: 20772

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indien, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 6th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chef

16b. Kind of Business/Industry: Private

17. Fethar's Nama (First, Middle, Last): Richard James

18. Mother's Nama (First, Middle, Maidan Sumama): Helen Turner

19a. Informant's Name/Ralationship (Type, Print): Oliver James/Nephew

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda): 4305 Canyonview Dr. Upper Marlboro, MD 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Othar (Specify)

20b. Place of Disposition (Nama of cematery, crematory or othar place): Lakemont Memorial

Date: 02/01/01

20c. Location - City or Town, Stata: Davidsonville, MD

21. Signature of Funeral Service Licensea: [signature]

22. Neme end Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

**To Be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

James, Richard @ 12:45 Dr. Koolaee / Jawaian

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cerdiac or raspiratory arrast, shock, or haart failura. List only one ceuse on each line. Approximata Intervel Batween Onset end Death

Immediate Cause (Final disaesa or condition rasulting in death): a. Intracranial bleeding

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata ceuse. Entar Underlying Ceuse (Disease or injury that initiated evants rasulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performad? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings eveilable prior to complation of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Was case refarred to medical examinar? 1 [ ] Yas 2 [X] No

26. Piece of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Othar (Specify)

27. Mannar of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Panding invastigation 6 [ ] Could not be datarmined

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Data of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Cartifiar (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data end place, and due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and piece, end due to tha ceusa(s) and manner stated.

29b. Signatura and title of cartifiar: M. [signature] MD 46260

29c. Licansa number

29d. Date signed (Month, Day, Year): 1 28 01

30. Neme and address of person who completed causa of daath (Item 23a) (Type, Print): M. SAEED KOOLAEE 7503 Surratts Rd. Clinton Md.

**State Registrar**

31. Data filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04700

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JACOB WOODROW KNOTTS
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 3:10 A.M.
4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 214 07 1995
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-7-1913
9. Birthplace (State or Foreign Country): WV

Usual Residance of Decedant

10a. State: PA
10b. County: Somerset
10c. City, Town or Location: Meyersdale
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 166 Knotts Road
10f. Zip Code: 15552
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Reca - American Indien, Bleck, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamentery/Secondery (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired): Laborer
16b. Kind of Businass/Industry: Manufacturing

17. Father's Neme (First, Middle, Last): Albert Lewis Knotts
18. Mother's Neme (First, Middle, Maiden Surneme): Minnie Catherine Davis

19a. Informent's Neme/Reletionship (Type, Print): Virginia A. Knotts, wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 166 Knotts Road, Meyersdale, PA 15552

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☒ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cametary, cremetory or other place): Mt. Lebanon Cemetery | Deta: 2-2-01
20c. Location - City or Town, Stete: Glencoe, PA

21. Signeture of Funeral Service Licensee: Harvey H Zeigler
22. Neme end Address of Facility: Harvey H. Zeigler Funeral Home, Hyndman, PA

**Physician /Medical Examiner**

23a. Part I. Entar tha disaase, or complications thet caused the daeth. Do not antar tha mode of dying, such as cardiac or respiratory errest, shock, or heart feilura. List only one ceuse on each line. | Approximete Intarval Between Onset end Death

Immediate Ceusa (Finel diseese or condition rasulting in death): a. Sepsis — 5 days
Due to (or es a consequanca of):
Sequantially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To tha best of my knowledga, death occurred at the time, dete end plece, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner**: On tha basis of axamination end/or invastigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier:
29c. License number: D0033280
29d. Date signed (Month, Day, Year): January 31, 2001

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. Sunil K. Gupta 625 Kent Avenue Cumberland, MD 21502

**State Registrar**

31. Date filed (Month, Dey, Year): FEB 01 2001
32. Registrer's Signeture: George D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No: 2001 04701

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: WILLIS LEE KESNER
2. Data of Daath — Month: JANUARY Day: 25, Yaar: 2001
3. Tima of Deeth: 11:29PM
4a Facility Nama *(If not institution, giva street and number)*: Memorial Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 232-48-1959
6. Sax: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Year)*: July 4,1932
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Rasidance of Decedent

10a. Stata: WV
10b. County: Mineral
10c. City, Town or Location: Keyser
10d. Insida City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: Rt. 6 Knobley Road
10f. Zip Code: 26726
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No — If Yes, Giva Yaar or Datas: Korean Conflict
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Race - Amaricen Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Educetion *(Specify only highast grada compliated)*: Elamentary/Secondary (0-12): 12 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Quality Control
16b. Kind of Businass/Industry: Paper Mill

17. Fathar's Nama *(First, Middla, Last)*: Willis Kesner
18. Mother's Name *(First, Middla, Meidan Sumama)*: Mary Oda McGuinness

19a. Informant's Name/Ralationship *(Type, Print)*: Daniel L. Kesner, I/ Son
19b. Mailing Address *(Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: Rt. 1, Box 185-A Keyser, WV 26726

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar piece)*: Omega-Alpha Cemetery — Data: Feb. 1 2001
20c. Location - City or Town, Stata: Short Gap, WV

21. Signatura of Funaral Sarvice Licensee: Brian L Smith
22. Name and Addrass of Facility: Smith Funeral Home, 85 S. Main Street Keyser, WV 26726

**Physician /Medical Examiner**

23a. Part1. Entar the disaesa, or complications that caused tha daath. Do not anter the moda of dying, such as cerdiac or raspiratory arrast, shock, or haart failura. List only ona causa on each line. — Approximata tntarval Batwaen Onsat and Deeth

Immediata Cause (Final disease or condition resulting in daath)
a. Coronary ARtery DiSease — >10yrs
Dua to (or as a consequance of):
b. HyperCholesterolemiA — >10yrs
Sequantially list conditions, if any, laading to Immadiate cause. Enter Underlying Ceuse (Diseesa or injury that initiated events resulting in death) Lest
Dua to (or as a consequance of):
c. Hypertension — >10 yrs
Dua to (or as a consequance of):
d.

Part II. **Other signiftcant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [✓] No
24b. Wara autopsy findings availabla prior to completion of ceusa of death? 1 [ ] Yas 2 [✓] No

25. Was casa rafarrad to medical axaminar? 1 [ ] Yas 2 [✓] No
26. Place of Death *(Check only ona)*: Hospital: 1 [ ] Inpatiant 2 [✓] ER/Outpatiant 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [✓] Naturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datermined
28a. Data of Injury *(Month, Dey Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28a. Place of Injury - At home, farm, straat, fectory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1 [✓] **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, date end place, end due to the ceuse(s) and mannar stated.

29b. Signature and title of cartifiar: [signature] MD
29c. Licansa number: D40095
29d. Data signed *(Month, Day, Year)*: 01/31/01

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): George Pellegrino, MD 710 Memorial AVE., Cumberland MD 21502

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

KESNER, WILLIS LEE 232 48 1959

Division of Vital Records, P.O. Box 68760,

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04702

JOHN C. KREADY 215-34-4264

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| John | C. | Kready | 01 | 31 | 2001 | 6:04PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Memorial Hospital & Medical Center | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 215-34-4264 | X 1☐ M 2☐ F | 66 Yrs. | | | | | May 16, 1934 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Allegany | Cumberland | 1☐ Yes 2☐ No X |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12003 North Branch Road | 21502 | USA |

| 11. Meritel Stetus | 12. Wes Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Bleck, White, etc. |
|---|---|---|---|
| 1☐ Never Merried 2☒ Merried X 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No X It Yes, Give Yeer or Detas: | 1☐ Yes 2☐ No X Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondery (0-12) | College (1-4or 5+) | | |
| 12 | | Truck Driver | Suburban Propane |

| 17. Fathar's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John H. Kready | Frances M (Short) |

| 19e. Interment's Neme/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Virginia L. Kready wife | 12003 North Branch Rd;Cumberland MD 21502 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| X 1☐ Buriel 2☐ Cramation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify) | Davis Memorial Cemeter | 2/03/2001 | Cumberland, MD |

| 21. Signelure of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ James J Scarpelli | Scarpelli Funeral Home, P.A. Cumberland, MD 21502 |

**Physician /Medical Examiner**

23a. Pert I. Enter the diseese, or complications that caused the deeth. Do not enter the mode ot dying, such es cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line.

| | | Approximete Intervel Between Onset end Death |
|---|---|---|
| Immediate Ceuse (Finat disaasa or condition resulting in death) | e. RESPIRATORY FAILURE | 2 DAYS |
| Due to (or es e consequenca of): | | |
| Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. CHRONIC OBSTRUCTIVE LUNG DISEASE | 20 YEARS |
| Due to (or as e consequence of): | | |
| | c. | |
| Due to (or es e consequence of): | | |
| | d. | |

Pert II. **Other significant conditions** contributing to death but not resulting in lha underlying cause given in Part I.

SQUAMOUS CELL CARCINOMA OF LUNG

| 23b. Did tobacco use contribute to the cause of death? | 24a. Wes en eutopsy performed? | 24b. Were eutopsy tindings aveileble prior to completion of cause ot deeth? |
|---|---|---|
| 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown | 1☐ Yes 2☒ No X | 1☐ Yes 2☐ No |

| 25. Wes case referred to medical exeminer? | 26. Place of Deeth (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No X | Hospitel: 1☒ Inpatient X 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Menner of Death | 28e. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Neturel X 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. X 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ William Lamm MD | D25406 | JANUARY 31, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAMM, WILLIAM D., M.D., 47 VIRGINIA AVENUE, CUMBERLAND, MD 21502

**State Registrar**

| 31. Data filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 02 2001 | ▶ Barbara G Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No 2001 04703

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Genevieve Margaret Keefer

2. Date of Death (Month, Day, Year): February 5, 2001

3. Time of Death: 1252

4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 102-14-2222

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 20, 1921

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedant

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Rawlings

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 18805 Volunteer Drive--P.O. Box

10f. Zip Code: 39 21557

10g. Citizan of Whet Country?: USA

11. Meritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Down Twist

16b. Kind of Businass/Industry: Textile

17. Fether's Neme (First, Middle, Last): Manuel Keefer

18. Mother's Name (First, Middle, Maiden Surneme): Ida B (Snyder)

19a. Informent's Name/Retationship (Type, Print): Margaret Peck

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): P.O. Box 39;Rawlings MD 21557

20a. Method of Disposition: 1☒ Buriet 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Martin's Cemetery

Date: 2/09/2001

20c. Location - City or Town, Stete: Little Orleans, Place

21. Signature of Funeral Service Licensee: James F Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrast, shock, or haert failura. List only one cause on each line.

Approximata Intarvel Between Onset end Death

Immediata Ceusa (Finel diseesa or condition resulting in death)

e. Profuse bleeding—aorta — 15 mts

Due to (or as e consaquance of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disaese or Injury that initieted evants resulting in death) Last

b. Excision Abdominal aortic aneurysm — 2 hrs.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Severe arthrio sclerosis

Emphysema

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveileble prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? Released 1☒ Yes 2☐ No

26. Place of Daath (Check only ona) Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mennar of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to tha ceusa(s) end mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to tha cause(s) and mannar stated.

29b. Signeture end title of certifier:

29c. License number: D13233

29d. Date signed (Month, Day, Year): February 7, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): A Sivan Pillai M.D. 915 Seton Drive Cumberland MD 21502

**State Registrar**

31. Date Filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: D Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

6/4 TKS

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04704

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Robert Edward KROUSE | Feb. 7 2001 | 6:40 a. m. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Williamsport Nursing Home | Williamsport | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-24-3150 | 1 [X] M 2 [ ] F | 72 Yrs. | | | Nov. 5 1928 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 318 Daycotah Avenue | 21740 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No *Specify:* | *Specify:* White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | Cabinet Maker | Pipe Organ Mfg. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Robert Krouse | Hilda Wagner |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Helen L. Krouse - Wife | 318 Daycotah Avenue Hagerstown, Md. 21740 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Rest Haven Cemetery | 2/9/01 | Hagerstown, Maryland |

21. Signature of Funeral Service Licensee: James L. Spicer

22. Name and Address of Facility: Minnich Funeral Home, 415 E. Wilson Blvd. Hagerstown, Md. 21740

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ASPIRATION PNEUMONIA | 5 DAYS |
| Due to (or as a consequence of): | b. DYSPHAGIA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): c. ADVANCED SENILE DEMENTIA | |
| Due to (or as a consequence of): | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J. Krouse MD | D33700 | February 7, 2001 |

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
154 N. Artizan St. Williamsport, MD 21795

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 08 2001 | Donna B Sparks |

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ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-0642-043
crn
Mason P. Keller

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 04705

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Dey Year | 3. Time of Death |
|---|---|---|
| Mason Palmer Keller | February 04, 2001 | 8:04 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington County Hospital | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplece (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 186-30-7449 | 1 X M 2 ☐ F | 61 Yrs. | | | January 4, 1940 | Penna. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Penna. | Franklin | Greencastle | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 9465 Browns Mill Rd. | 17225 | U.S.A. |

| 11. Marital Status | 12. Wes Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - Americen Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1962-65 | 1 ☐ Yes 2 X No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Machinist | Mack Trucks Inc. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surneme) |
|---|---|
| Elmer Jacob Keller Sr. | Margaret E. Palmer |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Jeffrey Dean Keller/Son | 4377 Coseytown Rd. Greencastle, Pa. 17225 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) | Dete | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) | Parklawns Memorial Gardens | 2/9/01 | Chambersburg, Pa. |

| 21. Signature of Funerat Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ H. Martin Zimmerman Jr. | Zimmerman And Son Funeral Home Inc. Greencastle Pa. |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONTACT GUNSHOT WOUND OF HEAD

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or es a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel deeth 3 ☐ Ectopic pregnancy 4 ☐ Pregnent et time of death 5 ☐ Other (specify) 9 ☐ Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probebly 4 ☐ Unknown | | |
|---|---|---|
| 24e. Was en autopsy performed? 1 X Yes 2 ☐ No | 24b. Were eutopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No | |

| 25. Was case referred to medicat examiner? 1 X Yes 2 ☐ No | 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |
|---|---|

**Medical Certification; To Be Completed by Physician/Medical Examiner**

| 27. Manner of Deeth | 26a. Date of Injury (Month, Dey, Year) | 26b. Time of Injury | 26c. Injury at Work? | 26d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☐ Netural 2 ☐ Accident 3 X Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 2/4/01 | 1540 M | 1 ☐ Yes 2 X No | SUBJECT SHOT SELF |

| 26e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| AT RESIDENCE | 9465 BROWNSMILL RD, GREENCASTLE, PA |

| 29a. Certifier (Check only one) | |
|---|---|
| 1 ☐ | **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner es stated. |
| 2 X | **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and manner stated. |

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ M.D. | O.C.M.E. | February 06, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY G. RIPPEON, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Dey, Year) | 32. Registrar's Signature |
|---|---|
| FEB 08 2001 | ▶ Barbara D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

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Amended
Item 23a. Line c.
WCHD/SC/2-2-01

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04706

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Marjorie Helena KROEGER | January 27 2001 | 12:45 pm |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Washington County Hospital | Hagerstown | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-18-9928 | 1☐ M 2☒ F | 77 Yrs. | | | Feb. 17,1923 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Hagerstown | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 219 Daycotah Avenue | 21740 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| unknown | unknown | homemaker | her own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Lester M. Mose, Sr. | Mary I. Colbert |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Judy Morningstar - daughter | 11628 Whitehall Rd., Smithsburg, Md. 21783 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Rest Haven Cemetery | 1-30-01 | Hagerstown, Maryland |

21. Signature of Funeral Service Licensee: Scott M Minnich

22. Name and Address of Facility: MINNICH FUNERAL HOME
415 E.Wilson Blvd., Hagerstown, Md. 21740

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | 1 hr |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Congestive Heart failure | 1 yr. |
| | Due to (or as a consequence of): | |
| | c. Arteriosclerotic Heart Disease | |
| | Due to (or as a consequence of): | |
| | d. Urinary tract infection | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Drader | D46561 | JAN. 27, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Qadir 20311 Leppans Rd Boonsboro, Md. 21713

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| JAN 3 0 2001 | ▶ Donna B Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Marjorie Helena Kroeger

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04707

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Louis Kirksey

2. Date of Death: Month 01 Day 24 Year 2001

3. Time of Death: 9:25 pm

4a. Facility Name (If not institution, give street and number): Fort Washington Hospital

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince George

**Funeral Director**

5. Social Security Number: 577 20 4607

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN. 10, 1922

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles County

10c. City, Town or Location: Waldorf

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 11080 Weymouth Court

10f. Zip Code: 20602

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Porter/Custodian

16b. Kind of Business/Industry: Govt/Private

17. Father's Name (First, Middle, Last): William Kirksey

18. Mother's Name (First, Middle, Maiden Surname): Rosa Young

19a. Informant's Name/Relationship (Type, Print): Geraldine Dixon/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2809 17th Street NE Washington DC 20018

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland National Cem.

Date: 1-30-01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Juwana Braxton

22. Name and Address of Facility: MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Pneumonia | 1 week |
| Due to (or as a consequence of): b. | Congestive Heart Failure | 1 week |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in death) Last — Due to (or as a consequence of): c. | Sepsis | 1 week. |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dermatomyositis

Decubitus Ulcers.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: D L Haye

29c. License number: D26352

29d. Date signed (Month, Dey, Year): Jan 25 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D L Haye 9131 Piscataway Rd Clinton Md

**State Registrar**

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: G. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04708

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Everett C. Kinder

2. Date of Death (Month, Day, Year): January 26, 2001

3. Time of Death: 9:10 A.M.

4a. Facility Name (If not institution, give street and number): Layhill Nursing Center

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 236 05 2459

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 1, 1915

9. Birthplace (State or Foreign Country): West Virginia

Usual Residance ot Decedant

10a. Steta: Virginia

10b. County: Fairfax

10c. City, Town or Location: Falls Church

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 6931 Westmoreland Road

10f. Zip Code: 22042

10g. Citizen of What Country?: United States

11. Merital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elemantary/Secondery (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Television

17. Father's Neme (First, Middle, Last): Theodore J. Kinder

18. Mother's Name (First, Middle, Maiden Surname): Sarah Yeager

19a. Intorment's Neme/Reletionship (Type, Print): Steve Kinder Son

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6931 Westmoreland Rd. Falls Church Virginia 22042

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify)

20b. Piece ot Disposition (Neme of cemetery, cremetory or other place): Riverdale Baptist Cemetery Date: January 29, 2001

20c. Location - City or Town, Stete: Largo Maryland

21. Signature of Funeral Service Licensee: Michael Bayler

22. Name end Address of Facility: Robert E. Evans Funeral Home 16000 Annapolis Road Bowie Maryland 20715

**Physician /Medical Examiner**

23a. Part1. Enter tha diseese, or complications that caused the deth. Do not entar the mode ot dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one ceusa on each lina.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in death)

e. Pneumonia

Dua to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b. Esophageal - Tracheal Fistula.

Due to (or es a consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner ot Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima ot Injury

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifiar (Check only one): 1 ☒ **Certifying Physician:** To tha best ot my knowledge, daath occurred at the time, date and place, and due to tha cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of axamination end/or investigation, in *my* opinion, daath occurred at tha time, data and place, and dua to tha cause(s) end menner stated.

29b. Signature and title of certifier: S.K. Angra, M.D.

29c. License number: D36980

29d. Date signed (Month, Day, Year): 1/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S.K. Angra, M.D. 344 University Blvd. West Silver Spring Maryland 20901

**State Registrar**

31. Deta tiled (Month, Day, Year): FEB 01 2001

32. Registrar's Signetura: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

4

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

Amended
Item# 18./WCHD
SC/2-9-01

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04709

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Dorothy Mae Little

2. Date of Death (Month, Day, Year): February 2 2001

3. Time of Death: 08:30

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 214-34-0188

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 12/21/1933

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedant

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 246 Bryan Place

10f. Zip Coda: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amaricen Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 12 Years; Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratired)*: Homemaker

16b. Kind of Businass/Industry: Personal Residence

17. Fathar's Nama *(First, Middla, Last)*: George Richard Bloyer

18. Mothar's Nama *(First, Middla, Maiden Sumama)*: Margaret Neomi ~~Kyser~~ Keyser

19a. Informant's Name/Ralationship *(Type, Print)*: John W. Little, Husband

19b. Mailing Addrass *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 246 Bryan Place, Hagerstown, MD 21740

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Rest Haven Cemetery Data: 02/05/2001

20c. Location - City or Town, Stata: Hagerstown, Maryland

21. Signature of Funaral Sarvice Licensee: ▶ P. Steven Danfelt, Jr. P. Steven Danfelt, Jr.

22. Nama and Address of Facility: Rest Haven Funeral Home 1601 Pennsylvania Ave. Hagerstown, MD 21742

**Physician /Medical Examiner**

23a. Part1. Entar tha disease, or complications that ceusad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaen Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. ANOXIC ENCEPHALOPATHY — 2 DAYS

Dua to (or as a consequence of):

b. ANASARCA. — 2 WKS

Sequantially list conditions, if any, laading to immadiata ceuse. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last

Dua to (or as a consequance of):

c. CONGESTIVE HEART FAILURE. — 2 WKS

Dua to (or as a consequence of):

d. ATRIAL FIBRILLATION

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was cesa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and place, and dua to tha ceusa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifier: ▶ [signature] MD

29c. Licansa number: D-40151

29d. Data signed *(Month, Day, Year)*: 2/2/01 11:30 AM

30. Nama and addrass of parson who completed ceusa of daath (Item 23a) (Type, Print): Dr J. Jones 249 Mill Street Hagerstown, Maryland

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit pass.

Lilly Dorothy Mae

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04710

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANN GRAY LAURI
2. Date of Death: Month FEBRUARY Day 4 Year 2001
3. Time of Death: 12:00 noon
4a. Facility Name (If not institution, give street and number): 20009 Rosebank Way, #205
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

**Funeral Director**

5. Social Security Number: 383-12-9882
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 29, 1920
9. Birthplace (State or Foreign Country): TENNESSEE

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WASHINGTON
10c. City, Town or Location: HAGERSTOWN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 20009 ROSEBANK WAY, #205
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): COREY (UMN) GRAY
18. Mother's Name (First, Middle, Maiden Surname): WOODIE (UMN) MITCHENER

19a. Informant's Name/Relationship (Type, Print): CATHY LAURI/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 190, KEEDYSVILLE, MARYLAND 21756

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WILSON CO. MEM. GARDENS
Date: 2/7/01
20c. Location - City or Town, State: LEBANON, TENNESSEE

21. Signature of Funeral Service Licensee: ▶ Paul M. Dean
22. Name and Address of Facility: BAST FUNERAL HOME 7606 Old NationalPike Boonsboro, Maryland 21713

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | EMPHYSEMA | 5 YEARS |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | HISTORY OF CIGARETTE SMOKING | 40 YEARS |
| Due to (or as a consequence of): | | |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): ASSISTED LIVING FACILITY
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Matthew G Beckwith MD
29c. License number: D053634
29d. Date signed (Month, Day, Year): 2-5-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW G. BECKWITH MD 11110 MEDICAL CAMPUS RD HAGERSTOWN MD 21742

**State Registrar**

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

01-0616-043
jhm
TONY ALLEN
LEWIS

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04711

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Tony Allen Lewis

2. Date of Death Month Dey Yeer: FEBRUARY 04, 2001

3. Time of Death: 23:00 PM

4a. Facility Name (If not institution, give street and number): 2209 ROBINWOOD COURT

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

**Funeral Director**

5. Social Security Number: 214-11-7501

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 32 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 1, 1969

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Washington

10c. City, Town or Location: Smithsburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14354 Pleasant Valley Rd.

10f. Zip Code: 21783

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Landon L. Lewis

18. Mother's Neme (First, Middle, Maiden Surname): Jo Ann Mason

19a. Informant's Name/Relationship (Type, Print): Landon L. Lewis (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 133 Cavetown, Md. 21720

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garfield U.M. Cemetery

Date: Feb. 9, 2001

20c. Location - City or Town, State: Garfield, Md.

21. Signature of Funeral Service Licensee: Dennis L. Davis

22. Name and Address of Facility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. Shotgun Wound of Chest

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobacco use contribute to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 2/4/01

28b. Time of Injury: 2010 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): Robinwood ct. Apt. 2A0

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pfece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: J. Clifton Locke MD

29c. License number: OCME

29d. Date signed (Month, Day, Year): FEBRUARY 05, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Clifton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04712

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Inez W. Middleton
2. Date of Death (Month, Day, Year): January 29, 2001
3. Time of Death: 17:35
4a. Facility Name (If not institution, give street and number): Saint Vincent dePaul Nursing Center
4b. City, Town, or Location of Death: Frostburg
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 212-10-6263
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 28-Oct-14
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 141 McCulloh Street
10f. Zip Code: 21532-
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Coning Department
16b. Kind of Business/Industry: Textile Manufacturing

17. Father's Name (First, Middle, Last): Floyd Middleton
18. Mother's Name (First, Middle, Maiden Surname): Vera Dalley

19a. Informant's Name/Relationship (Type, Print): Betty Harden Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 132 McCulloh Street Frostburg Maryland 21532-

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Frostburg Memorial Park
Date: 01-Feb-01
20c. Location - City or Town, State: Frostburg, Maryland

21. Signature of Funeral Service Licensee: John R. Durst
22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) e. | Cerebro-vasculor accident | 5 hours |
| Due to (or as a consequence of): | diabetes | 10 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. | | |
| Due to (or as a consequence of): | ASCVD | 10 years |
| c. | | |
| Due to (or as a consequence of): | | |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Angela H. Roque MD
29c. License number: D - 13166
29d. Date signed (Month, Day, Year): January 30, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Angel H. Roque, M.D., 48 Tam Terrace, Frostburg, Maryland 21532

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04713

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOHN SAMUEL McKEE

2. Date of Death (Month, Day, Year): February 3 2001

3. Time of Death: 2230

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington County

**Funeral Director**

5. Social Security Number: 220-10-0426

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 4, 1918

9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: MD

10b. County: Washington Co.

10c. City, Town or Location: Clear Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13344 Blairs Valley Road

10f. Zip Code: 21722

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forcas? 1☒ Yes 2☐ No. If Yes, Give Yaar or Detas: 1944 1946

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada complated): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Mechanic

16b. Kind of Business/Industry: Equipment Manufactur.

17. Father's Neme (First, Middle, Last): John A. McKee

18. Mother's Neme (First, Middle, Maiden Surneme): Clara Jane Hull

19a. Informent's Neme/Reletionship (Type, Print): Hildred L. McKee/Wife

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 13344 Blairs Valley Road, Clear Spring, MD 21722

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Ramoval from Stata 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): St. Paul Cemetery

Date: Feb. 6

20c. Location - City or Town, State: Clear Spring, MD

21. Signeture of Funerel Service Licensee: Douglas A. Fiery

22. Name and Address of Facility: Donald Edwin Thompson Funeral Home, Inc. 13607 National Pike, Clear Spring, MD 21722

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feildre. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth): a. INTRACEREBRAL HEMORRHAGE — 1 HOURS

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causs of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mennar of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: D Wooster

29c. License number: D 22043

29d. Date signed (Month, Dey, Year): 2/5/01

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. Wooster 11110 Medical Campus Rd Hag. Md. 21742

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 05 2001

32. Registrer's Signeture: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Mc Kee, John

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04714

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: HERBERT FRANKLIN MARTIN, JR.

2. Date of Death Month Day Year: February 2, 2001

3. Time of Death: 6:18 A.M.

4a Facility Name *(If not institution, give street and number)*: Memorial Hospital & Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 236-12-6293

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 24,1918

9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: LAVALE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12211 PROUD DR. NW

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- it Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DRIVER/SALESMAN

16b. Kind of Businass/Industry: BAKERY

17. Fethar's Neme *(First, Middle, Last)*: HERBERT F. MARTIN, SR.

18. Mother's Name *(First, Middle, Maiden Sumame)*: ROSE NELL HARRIS

19a. Informant's Name/Relationship *(Type, Print)*: AVERIL D. MARTIN - WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12211 PROUD DR. NW,LAVALE,MD 21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: SUNSET MEMORIAL PARK

Date: FEB 5,2001

20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licansee: Douglas S Hafer

22. Name and Address of Facility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE,MD 21502

**Physician /Medical Examiner**

23a. Part1. Enter the disease or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Coronary Artery Disease — 15 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or as a consequence of):

d.

Part ff. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was casa rafarred fo medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straet, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and manner es steted. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sunil Gupta

29c. License number: D0033280

29d. Date signed *(Month, Day, Year)*: Feb 2, 2001

30. Name and address of persan who completed cause of death (Item 23a) (Type, Print): Dr. Sunil K. Gupta 625 Kent Avenue Cumberland, MD 21502

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: Barbara B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

8

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04715

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Neil Meyers
2. Data of Death (Month, Day, Year): February 3, 2001
3. Time of Death: 7:45 P.M.
4a. Facility Name (If not institution, giva street and number): 13514 Spriggs Rd.
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 219-14-9814
6. Sex: 1 [X] M 2 [ ] F
7. Aga (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 21, 1926
9. Birthplaca (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stata: Md.
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 13514 Spriggs Rd.
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A

11. Marital Stetus: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Give Yaar or Dates: 41-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Manger
16b. Kind of Business/Industry: Food Store
17. Father's Nema (First, Middle, Last): Jacob Meyers
18. Mothar's Nama (First, Middle, Maiden Surname): Lottie Myers
19a. Informant's Name/Ralationship (Type, Print): Patsy L. Meyers (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 13514 Spriggs Rd. Hagerstown, Md. 21742
20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Smithsburg Crematory — Data: Feb. 5, 2001
20c. Location - City or Town, State: Smithsburg, Md.
21. Signature of Funeral Service Licensee: Dennis L. Davis
22. Nama and Addrass of Facility: Davis Funeral Home, 12525 Bradbury Ave. Smithsburg, Md. 21783

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disaesa, or complicetions thet caused tha daath. Do not enter tha moda of dying, such as cardiac or respiretory errest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intervel Batween Onset and Death

Immediata Ceuse (Finai diseesa or condition rasulting in death)
a. Sarcoma — 2 months

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseasa or injury thet initieted evants rasulting in daath) Last
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Ware autopsy findings eveilable prior to complation of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case rafarred to medical examiner? 1 [ ] Yes 2 [X] No

26. Placa of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending invastigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1 [X] **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigetion, in my opinion, deeth occurred at the tima, date end plece, end due to the cause(s) end mannar stated.

29b. Signatura end titia of certifier: Michael J. McCormack MD
29c. License number: 041667
29d. Data signed (Month, Day, Year): 2.5.01

30. Name end eddress of person who complated causa of death (Item 23a) (Type, Print): Michael J. McCormack 11110 Medical Campus Hagerstown MD 21742

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerei director, page 2 should be detached for usa as the burial-transit

**State Registrar**

31. Data filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signatura: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04716

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Cora Mortley
2. Date of Death (Month, Day, Year): Jan. 24, 2001
3. Time of Death: 2:17 PM
4a. Facility Name (If not institution, give street and number): 7620 Maple Ave. #511
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 214-70-1062
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 5, 1918
9. Birthplace (State or Foreign Country): Guyana

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7620 Maple Ave. #511
10f. Zip Code: 20912
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): Martha Hunt

19a. Informant's Name/Relationship (Type, Print): Winston London/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2501 Naylor Rd. SE Washington, D.C. 20020

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glenwood Cemetery
Date: 2-1-01
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: D. L. Marshall
22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Heart Attack | Immediate |
| Due to (or as a consequence of): | b. Atrial Fibrillation | 2 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): c. Hypertension | 4 years |
| | Due to (or as a consequence of): d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Byoung Lee
29c. License number: D0021033
29d. Date signed (Month, Day, Year): 2/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Byoung K. Lee, M.D. 13000 Georgia Ave. Silver Spring, MD. 20906

**State Registrar**

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04717

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JAMES N. MERRIWETHER
2. Date of Death (Month, Dey, Year): JAN. 28, 2001
3. Time of Death: 6:45 AM
4e. Facility Name (If not Institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 719-10-7051
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthdey): 85 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 9-6-15
9. Birthplece (State or Foreign Country): FLA.

Usuel Residence of Decedent

10e. Stete: DC
10b. County:
10c. City, Town or Location: WASHINGTON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2516 - 36TH STREET, S. E.
10f. Zip Code: 20020
10g. Citizen of Whet Country?: U. S. A.
11. Marital Stetus: 1 [ ] Never Merried 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 7-29-43 1 [X] Yes 2 [ ] No If Yes, Give Year or Detes: 4-11-46
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): | College (1-4or 5+): 4 YRS.
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): RIGGER
16b. Kind of Business/Industry: NAVAL RESERACH
17. Father's Neme (First, Middle, Last): EDDIE WILLIE MERRIWETHER
18. Mother's Name (First, Middle, Maiden Surneme): PERNINNA CUNNINGHAM
19e. Informent's Neme/Reletionship (Type, Pnint): MAYME RUTH MERRIWETHER-WIFE
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2516 - 36TH ST., S. E. WASH., DC 20020
20e. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): LINCOLN MEMORIAL CEMETERY | Dete: 2/3/01
20c. Location - City or Town, Stete: SUITLAND, MD
21. Signature of Funeral Service Licensee: Theodore C. Pinckney
22. Name end Address of Fecility: PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N. E. WASH., DC 20002

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line. (Approximate Interval Between Onset and Deeth)

Immediete Ceuse (Finel disease or condition resulting in deeth)
e. RESPIRATORY FAILURE
Due to (or es e consequenca of):
b. ASPIRETION PNEUMONIA
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in death) Lest
Due to (or es e consequenca of):
c.
Due to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
GASTIC TUBE
DEMENTIA

23b. Did tobecco uas contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No
25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpetient 2 [X] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es steted. 2 [ ] **Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted.
29b. Signature and title of certifier:
29c. License number: D56214
29d. Date signed (Month, Dey, Year): 1/30/01
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): KATARZYNA OSTRZENSKA, M. D. 2309 SHOREFIELD ROAD WHEATON, MD 20902

**State Registrar**

31. Dete filed (Month, Dey, Year): JAN 31 2001
32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

12

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04718

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thomas J. Mulrenin
2. Data of Death (Month, Day, Yaar): January 28, 2001
3. Tima of Death: 9:15 A.M.
4a. Facility Nama (If not institution, giva street and number): Bowie Health Center
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 057 20 2374
6. Sex: 1☒ M 2☐ F
7. Aga (In yrs. last birthday): 73 Yrs. — If Undar 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Dec. 10, 1927
9. Birthplaca (Stata or Foreign Country): New York

Usual Rasidence of Decedant

10a. Stata: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 12623 Milburn Lane
10f. Zip Coda: 20715
10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yes, Giva Yaar or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Raca - Amarican Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): 12 — Collega (1-4or 5+): 0
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: AT&T

17. Fathar's Nama (First, Middla, Last): Thomas J. Mulrenin, Sr.
18. Mothar's Nama (First, Middla, Maiden Sumama): Irene Timoney

19a. Informant's Name/Ralationship (Type, Print): Elaine L. Mulrenin Wife
19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 12623 Milburn Lane Bowie Maryland 20715

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Name of camatary, cramatory or othar place): Resurrection Cemetery — Date: Jan. 31, 2001
20c. Location - City or Town, Stata: Clinton Maryland

21. Signafura of Funeral Service Licensee: Michael L. Bylen
22. Nama and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that causad the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrast, shock, or haart failura. List only one ceuse on eech lina.

Approximete Intarval Betwaan Onset and Death

Immedieta Causa (Final disaasa or condition rasulting in death)
a. Congestive Heard Failure. — 4 years

Dua to (or as a consequanca of):
b. Coronary Artery Disease — 15 years

Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Ceuse (Disease or Injury that initiated avents rasulting in death) Last
Dua to (or as a consequance of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying cause givan in Part I.
Chronic Obstructive Pulmonary Disease
Drabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Wara autopsy findings available prior to complation of ceusa of daath? 1☐ Yas 2☐ No

25. Was casa refarrad to medical examinar? 1☐ Yas 2☑ No
26. Placa of Daath (Check only ona) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Residanca 6☒ Othar (Specify) Health Center

27. Manner of Deeth: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☑ **Certifying Physician:** To the best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and manner as statad. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to tha cause(s) and mannar statad.

29b. Signatura and title of certifier: MD
29c. Licansa number: D50343
29d. Data signad (Month, Day, Year): January 29, 2001

30. Nama and addrass of person who complafed causa of daath (Item 23a) (Type, Print): Kelvin Hao, MD 3231 Superior Lane, Suite A-6, Bowie, Maryland 20715

**State Registrar**

31. Data filed (Month, Dey, Year): FEB 01 2001
32. Registrar's Signatura: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

16

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04719

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Richard Mailon Martin Sr.

2. Date of Death: Month 02 Day 04 Year 01

3. Time of Death: 2:50pm

4a. Facility Name (If not institution, give street and number): Caroline Nursing Home

4b. City, Town, or Location of Death: Denton

4c. County of Death: Caroline

**Funeral Director**

5. Social Security Number: 212-18-0376

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 8, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Denton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8291 Somerset Lane

10f. Zip Code: 21629

10g. Citizen of What Country?: USA

11. Maritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1945

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): maintenance machinist

16b. Kind of Business/Industry: shipyard

17. Father's Name (First, Middle, Last): Nathaniel Martin

18. Mother's Name (First, Middle, Maiden Surname): Catherine Sara Ports

19a. Informent's Neme/Reletionship (Type, Print): Richard Martin Jr son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8291 Somerset Lane Denton, Maryland 21629

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Eastern Shore Veteran | Date: Feb 8 2001

20c. Location - City or Town, Stete: Hurlock, Maryland

21. Signature of Funeral Service Licensee: ▶ Meyer (Fleegle

22. Name end Address of Facility: Fleegle and Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediete Cause (Final diseese or condition resulting in death): e. metastatic prostate carcinoma — years

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last:

b. Due to (or es a consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D0047534

29d. Date signed (Month, Day, Year): 2/5/01

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Wafik Zaki MD 920 Market Street Denton, Maryland 21629

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 0 8 2001

32. Registrar's Signature: ▶ Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Amended
Items # 7. & 8.
WCHD/SC/2-8-01

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

2001 04720
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Darlene Rae Oyler | February 7, 2001 | 3:10 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Reeder's Memorial Home | Boonsboro | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-20-0041 | 1☐ M 2☒ F | ~~74~~ 75 Yrs. | | | Jan. 19, ~~1927~~ 1926 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Washington | Smithsburg | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 12106 Crystal Falls Dr. | 21783 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Inspector | Book Co. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Herman H. Lewis | Hilda R. Harne |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Judson E. Oyler Sr. (Husband) | 12106 Crystal Falls Dr. Smithsburg, Md. 21783 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Smithsburg Crematory | Feb. 8, 2001 | Smithsburg, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Dennis L. Davis | Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. pneumonia | 3 week |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

diabetes, end-stage Alzheimers

| 23b. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown | 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ RGuedenet | D32518 | 2/7/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/301-432-2222

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 07 2001 | |

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Name: Darlene Rae Oyler
**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

ADH
OKWESUNA OKOJIE
01-0581-033

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM 23,27 per ME G793 032701SS

Reg. No. 2001 04721

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): OKWESUNU OKOJIE
2. Date of Death (Month, Day, Year): FEBRUARY 2, 2001
3. Time of Death: 1414 M
4a. Facility Name (If not institution, give street and number): FORT WASHINGTON HOSPITAL
4b. City, Town, or Location of Death: FORT WASHINGTON
4c. County of Death: PRINCE GEORGES

**Funeral Director**

5. Social Security Number: N/A
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months 9 Days
If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): April 18, 2000
9. Birthplace (State or Foreign Country): Wash. DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Accokeek, MD
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 14505 Foust St.
10f. Zip Code: 20607
10g. Citizen of What Country? US

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☐No Specify:
14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 0
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Ken Okojie
18. Mother's Name (First, Middle, Maiden Surname): Lawrentta Ehikioya

19a. Informant's Name/Relationship (Type, Print): Ken Okojie (father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14505 Foust St. Accokeek, MD 20607

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery
Date: 2/7/01
20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: Alex S Pope Jr
22. Name and Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville, MD 20747

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDITIS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S Radentz, M.D.
29c. License number: OCME
29d. Date signed (Month, Day, Year): FEBRUARY 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: pennie G. Sparks

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

Items 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04722

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Edith Viola Plummer
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 1805
4a. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 216-14-1962
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: December 16, 1921
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11013 Welsh Hill Road S.W.
10f. Zip Code: 21532
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Leslie Michael Jones
18. Mother's Name *(First, Middle, Maiden Surneme)*: Rachael E. Plummer

19a. Intormant's Neme/Relationship *(Type, Print)*: Thomas A. Plummer Sr.-son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: Rt.3,Box 86AA, Bruceton Mills, W.V. 26525

20a. Method of Disposition: 1☒ Buriai 2☐ Cremetion 3☐ Removal trom State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Frostburg Memorial Park
Date: February 03, 2001
20c. Location - City or Town, Stete: Frostburg,Md.

21. Signature of Funerel Service Licensee: ▶ James E. McKenzie
22. Name end Address of Facility: Eichhorn-McKenzie Funeral Home P.A.,Lonaconing,Md. 21539

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ACUTE Pulmonary Embolism — 1 HOUR

Due to (or as a consequenca ot):
b. Extensive thrombophlebitis Left lower Xtremity — 12 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or es e consequence of):
c.

Due to (or as a consequenca ot):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Old Cerebrovascular accident
Seizure Disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy tindings eveliable prior to completion of cause ot death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner ot Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time ot Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, tarm, street, tactory, offica building, etc. *(Specify)*
28t. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best ot my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis ot examinetion end/or investigation, in my opinion, death occurred at the time, dete and pleca, and due to the cause(s) and menner steted.

29b. Signature end title of certifier: ▶ S. Chang MD
29c. License number: D 25638
29d. Date signed *(Month, Day, Year)*: Feb. 1, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type/Print): STEPHANIE CHANG MD 10701 New George Creek S.W. Suite 3 Frostburg Maryland 21532

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 05 2001
32. Registrer's Signeture: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04723

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2

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**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Evelyn Merle Preston
2. Date of Death: Month February Day 3 Year 2001
3. Time of Death: 12:44PM
4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 215-12-2120
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 25 1921
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD.
10b. County: Allegany
10c. City, Town or Location: Barton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 19706 Old Miller Road
10f. Zip Code: 21521
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Housework
17. Father's Name (First, Middle, Last): Winter Paugh
18. Mother's Name (First, Middle, Maiden Surname): Christine McVicker
19a. Informant's Name/Relationship (Type, Print): Toby Preston / son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19702 Old Miller Road, Barton, Maryland 21521
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cumberland Crematory
Date: 2/05/2001
20c. Location - City or Town, State: Cumberland, Maryland
21. Signature of Funeral Service Licensee: ▶ F. Wayne Boal
22. Name and Address of Facility: Boal Funeral Home, 111 Church St., Westernport, Md. 21562

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | CONGESTIVE HEART FAILURE | Many 5 yrs |
| Due to (or as a consequence of): b. | cardiomyopathy | unknown |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

& chronic Renal failure
HYPERTENSION DIABETES MELLITUS.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D26907
29d. Date signed (Month, Day, Year): February 04 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harjit Sidhu M.D. 925 Bishop Walsh Road Cumberland MD 21502

**State Registrar**

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: ▶ [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Amended #2, 206, C. nlo, 2/5/01, Allegany Co.
Amend Item 15 per FH 7/02/01dhb G797

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No 2001 04724

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Dylan | Valentino | Paugh | Feb 1, 2001 | 10:45pm |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 119 W. Oldtown Road-Ft Cumb Homes | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-35-2416 | 1☐M X 2☐F | 9 Yrs. | | | Nov 9, 1991 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Allegany | Cumberland | 1☐Yes 2☐No X |

| 10a. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 119 W. Oldtown Road | 21502 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☐No X Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) ~~12~~ 3 | College (1-4or 5+) | student | elementary school |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Melvin E. Paugh | Traci L (Morris) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Traci L. Douglass mother | 119 W. Oldtown Road;Cumberland, MD21502 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Sunset Memorial Park ~~Mount Zion Church Ceme~~ 2001 | 2/05 | Cumberland, MD ~~Swanton, MD~~ |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| James F Scarpelli | Scarpelli Funeral Home P.A. Cumberland, Maryland 21502 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Oligodendroglioma (Brain Tumor) | 18m |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☑No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☑No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☑No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Allen Haworth DO | H50243 | Feb 2, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Allen Haworth 500 Greene Street Cumberland MD 21502

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 05 2001 | Penny B Sparks |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at this

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2
MD

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04725

Helen PATTISON 215-36-0024

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Helen Anne Patterson
2. Date of Death: Month JANUARY Day 29 Year 2001
3. Time of Death: 1822
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 215-36-0024
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05/04/1940
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Delaware
10b. County: Sussex
10c. City, Town or Location: Delmar
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: Rt 1 Box 4064-10
10f. Zip Code: 19940
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): cafeteria
16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Wesley Harrington
18. Mother's Name (First, Middle, Maiden Surname): Dorothy Hill Jester

19a. Informant's Name/Relationship (Type, Print): husband William Franklin Patterson, Sr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt 1 Box 4064-10, Delmar, DE 19940

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Springhill Memory Gardens | Date: 2/2/2001
20c. Location - City or Town, State: Hebron, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Short Funeral Home, 13 E. Grove Street, Delmar, DE 19940

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ASCD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D0054127
29d. Date signed (Month, Day, Year): 1/30/01

5 DA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan DAVIS MD 3 Bistate Blvd Delmar MD 21875

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: [signature]

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04726

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ann Marie Pagliochini

2. Date of Death Month Day Year: January 28, 2001

3. Time of Death: 1:50PM

4a. Facility Name *(If not institution, give street and number)*: 7507 Riverdale Road Apt. 2053

4b. City, Town, or Location of Death: New Carrollton

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 218-20-1677

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 29, 1926

9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: New Carrollton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7507 Riverdale Road Apt 2053

10f. Zip Code: 20784

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Benjamin Edward Jarboe

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Elizabeth Heisler

19a. Informant's Name/Relationship *(Type, Print)*: Jan Freeman (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7507 Riverdale Road Apt 2053 New Carrollton, MD 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland State Veterans Cemetery Date: Feb. 5, 2001

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: Mark D. Lee

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton MD20735

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Metastatic Lung Cancer — 2 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 43361 (MD)

29d. Date signed *(Month, Day, Year)*: January 30, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert S. Siegel M.D. 2150 Pennsylvania Ave. N.W. Washington DC 20037

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04727

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Robert Lee Paddy, Sr.

2. Date of Death (Month, Day, Year): January 28, 2001

3. Time of Death: 0142

4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 213-22-1030

6. Sex: 1 XX M 2 ☐ F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 27, 1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Capital Heights

10d. Inside City Limits: 1 ☐ Yes 2 ☒ XX No

10e. Street and Number: 9413 Firtree Park Street

10f. Zip Code: 20743

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ XX Yes 2 ☐ No If Yes, Give Year or Dates: 1948-1950

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yas 2 ☒ X No Specify:

14. Race - American Indien, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman/Carpenter

16b. Kind of Businass/Industry: Federal Government GSA

17. Fether's Name (First, Middle, Last): Morris C. Paddy

18. Mother's Name (First, Middle, Maiden Surname): Helen E. Hall

19a. Informant's Name/Relationship (Type, Print): Bonnie L. Paddy (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Coda): 9413 Firtree Park Street Capital Heights, MD20743

20a. Method of Disposition: 1 ☒ X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Piece of Disposition (Nama of cemafary, crematory or other piece): Ft. Lincoln Cemetery Date: February 1, 2001

20c. Location - City or Town, Stata: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Mark D. Lee

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only one cause on aach line. (Approximata Intarval Betwean Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Hypertensive Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or es a consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of daath? 1 ☐ Yes 2 ☐ No N/A

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Rasidance 6 ☐ Othar (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvester

29c. License number: H0053927

29d. Date signed (Month, Day, Year): January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

**State Registrar**

31. Data filed (Month, Day, Year): JAN 30 2001

32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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VA

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended # 4c & 10 b. PG, GC, 1/31/01

# Certificate of Death

Reg. No. 2001 04728

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: LOUISE V. POWELL
2. Date of Death Month / Day / Year: January 25, 2001
3. Time of Death: 5:25 AM
4a. Facility Name *(If not institution, give street and number)*: SOLOMONS NURSING CENTER
4b. City, Town, or Location of Death: Solomons
4c. County of Death: ~~Anne Arundel~~ Calvert

**Funeral Director**

5. Social Security Number: 578-18-0147
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 5, 1917
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Calvert ~~Anne Arundel~~
10c. City, Town or Location: Solomons
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 13325 Dowell Road
10f. Zip Code: 20688
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrator
16b. Kind of Business/Industry: ~~Banking~~ Industry

17. Father's Name *(First, Middle, Last)*: Andrew B. Roles
18. Mother's Name *(First, Middle, Maiden Surname)*: Lucy Lovelace

19a. Informant's Name/Relationship *(Type, Print)*: June Robinson/Granddaughter-in-law
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8185 Heron Lane, Lusby, MD 20657

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery
Date: 1/29/01
20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: Tonya Montgomery-Chestnut
22. Name and Address of Facility: CEDAR HILL FUNERAL HOME, INC. 4111 Pennsylvania Ave., Suitland, MD 20746

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Congestive Heart Failure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CVA
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Joseph Barth
29c. License number: D0572242
29d. Date signed *(Month, Day, Year)*: January 25, 2000
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Joseph Barth M.D. 100 Hospital Road, Suite 310, Prince Frederick, MD 20678

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04729

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ANNE RUTH PERRY
2. Date of Death Month/Day/Year: 01/22/2001
3. Time of Death: 7:30 PM
4a. Facility Name *(If not institution, give street and number)*: MANOR CARE
4b. City, Town, or Location of Death: HYATTSVILLE
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 256-14-4718
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 96 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 08/24/1904
9. Birthplace *(State or Foreign Country)*: GEORGIA

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: HYATTSVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8700 JONES MILL RD.
10f. Zip Code: 20815
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SECRETARY
16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name *(First, Middle, Last)*: ALFRED THADDEUS PERRY
18. Mother's Name *(First, Middle, Maiden Surname)*: MARY CATHERINE BUCKLEY

19a. Informant's Name/Relationship *(Type, Print)*: FREERICA CAMERON( NIECE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 24 ROCKFIELD CRESCENT,OTTAWA, CANADA

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: GEORGETOWN MEDICAL
Date: 01/23/01
20c. Location - City or Town, State: WASHINGTON D.C.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: AUSTIN ROYSTER FUNERAL HOME 3821 14th ST. WASH. D.C. 20011

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarct — Immediate

Due to (or as a consequence of):
b. Coronary Artery Disease — 5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] James A. Foster
29c. License number: D04179
29d. Date signed *(Month, Day, Year)*: 1-22-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James A. Foster MD 5530 Wisc Chevy Chase MD

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 29 2001
32. Registrar's Signature: [signature] Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

(2)

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04730

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MALCOLM WAYNE REED SR.

2. Data of Daeth: Month January Day 31, Year 2001

3. Time of Deeth: 11:48 AM

4a Facility Name (If not institution, giva street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 215-78-0515

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 23, 1961

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Sharpsburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7216 Dustin Drive

10f. Zip Code: 21782

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired): Roofer

16b. Kind of Business/Industry: Roofing Company

17. Father's Name (First, Middle, Last): Herman Leroy Reed Sr.

18. Mother's Nama (First, Middle, Maiden Surname): Mary Lee Thompson

19a. Informent's Neme/Relationship (Type, Print): Peggy A. Lowe Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 7216 Dustin Drive, Sharpsburg, Maryland 21782

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Rose Hill Cemetery

Date: 02-03-2001

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: R. Noel Brady

22. Nama and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)

e. RESPIRATORY FAILURE — 10 DAYS

Due to (or as a consequence of):

b. ASPIRATION PNEUMONIA — 1(

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

Due to (or es a consequence of):

c. LIVER FAILURE — 1.

Due to (or as a consequenca of):

d. CHRONIC ALCOHOL ABUSE — 4 YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to complation of causa of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Straet and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 040622

29d. Date signed (Month, Day, Year): FEBRUARY 2, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): BRENDA L. CONNA - MD 19236 MEADOWVIEW DR HAGERSTOWN MD

**State Registrar**

31. Data filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signatura:

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

Reed, Malcolm Wayne

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04731

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: JULIA ANN REICHARD

2. Date of Death (Month, Day, Year): Feb. 3 2001

3. Time of Death: 7:25 AM

4a. Facility Name *(If not institution, give street and number)*: Fahrney-Keedy Nursing Home

4b. City, Town, or Location of Death: Boonsboro

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 217-28-2224

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV 19, 1930

9. Birthplace *(State or Foreign Country)*: MARYLAND

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: BOONSBORO

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8507 MAPLEVILLE ROAD

10f. Zip Code: 21713

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: REGISTERED NURSE

16b. Kind of Business/Industry: NURSING HOME

17. Father's Name *(First, Middle, Last)*: JOHN ROWLAND REICHARD

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY KATHRYN MARTIN

19a. Informant's Name/Relationship *(Type, Print)*: JAMES M. REICHARD, BROTHER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: POST OFFICE BOX 67, FALLING WATERS, WV 25419

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MANOR CEMETERY

Date: 2/7/01

20c. Location - City or Town, State: TILGHMANTON, MARYLAND

21. Signature of Funeral Service Licensee: Paul M Dean

Paul m. Dean

22. Name and Address of Facility: BAST FUNERLAL HOME 7606 OLD NATIONAL PIKE, BOONSBORO, MD 21713

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. END STAGE BREAST CANCER METASTASES | 2yr |
| Due to (or as a consequence of): | b. Hypertension | 10yr |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Anemia | 2yr |
| Due to (or as a consequence of): | d. Diabetes Mellitus | 10yr |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Metabolic Bone Disease

Osteoporsis

thrombocytopenia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allen Reilly MD

29c. License number: D54749

29d. Date signed *(Month, Day, Year)*: Feb. 4 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 8507 Mapleville Road Boonsboro, MD 21713-1844

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signature

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Julia Ann Reichard

Julia Ann Reichard

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04732

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): RANDOLPH THOMAS RICE

2. Date of Death (Month, Day, Year): FEBRUARY 2 2001

3. Time of Death: 5:15 AM

4a. Facility Name (If not institution, give street and number): 21012 SAN MAR ROAD

4b. City, Town, or Location of Death: BOONSBORO

4c. County of Death: WASHINGTON

**Funeral Director**

5. Social Security Number: 220-28-7877

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 28, 1923

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: BOONSBORO

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 21012 SAN MAR ROAD

10f. Zip Code: 21713

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRACKMAN

16b. Kind of Business/Industry: RAILROAD

17. Father's Name (First, Middle, Last): OTHO CARLTON RICE

18. Mother's Name (First, Middle, Maiden Surname): BLANCHE LOVETTA THOMAS

19a. Informant's Name/Relationship (Type, Print): LUCIA RICE/SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21012 SAN MAR ROAD, BOONSBORO, MARYLAND 21713

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY

Date: 2/5/01

20c. Location - City or Town, State: ROHRERSVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean

22. Name and Address of Facility: BAST FUNERAL HOME, 7606 Old National Pike, Boonsboro, Maryland 21713

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Small intestinal cancer — 5 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D46473

29d. Date signed (Month, Day, Year): 2/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hind Hamdan, MD; 363 S. Cleveland Ave; Hagerstown, MD 21740

**State Registrar**

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04733

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Gladys L. RAINEY

2. Date of Death: Month 1 Day 30 Year 01

3. Time of Death: 0919

4a. Facility Name (If not institution, give street and number): ATLANTIC GENERAL Hospital

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WORCESTER

**Funeral Director**

5. Social Security Number: 217-28-3386

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-10-33

9. Birthplace (State or Foreign Country): MARYLAND

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Del | 10b. County: Sussex | 10c. City, Town or Location: Clarksville | 10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: Rt 2 Bx 35 | 10f. Zip Code: 19970 | 10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRO - AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self-Emp

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): William R. Jones

18. Mother's Name (First, Middle, Maiden Surname): Sussie Johnson

19a. Informant's Name/Relationship (Type, Print): Charles R. Johnson/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9914 Beaverdam Creek Rd. Berlin

20a. Mathod of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): Curtis Ch. Cemetery | Date: 2/3/01

20c. Location - City or Town, State: Bishopville md.

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Bunting Smith F/H 917 W. Isabella St. Salisbury md. 21801

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. myocardial infarction — 5 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other signifkant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uee contributa to the cauee of death? 1☐ Yee 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha ceuse(s) and menner stated.

29b. Signature and title of certifier ▶ physician

29c. License number: H44283

29d. Date signed (Month, Day, Year): 2/1/01

30. Nama and addrass of person who completed cause of daath (Item 23a) (Type, Print): Robert Durkin 9733 Healthway Drive Berlin, MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 0 1 2001

32. Registrer's Signeture ▶ Geneva B Sparks

DHMH 16 Rev 6/95

3 02-08-01 4 DQ

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 04734

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|
| ORIEL | RICHARDSON | January 20 2001 | 5:35AM |

| 4a Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| UNION MEMORIAL HOSPITAL | BALTIMORE | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 239-20-3737 | 1 [X] M 2 [ ] F | 80 Yrs. | | | 03-30-1920 | KENLY, NC |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | | BALTIMORE | 1 [X] Yes 2 [ ] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 312 E 26th STREET | 21218 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | STEEL WORKER | N/A |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| THOMAS BAGLEY | MARY WHITFIELD |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| DORCAS RICHARDSON - WIFE | 312 E. 26th STREET, BALTIMORE, MD 21218 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | GARRISON FOREST VET. | 1/26/01 | OWINGS MILLS MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| B. C. Taylor | TAYLOR"S FUNERAL HOME 1722 NORTH CAPITOL ST.,NW WASH.DC 20001 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | Three Weeks |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [ ] Yes 2 [X] No | 1 [ ] Yes 2 [X] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [ ] Yes 2 [X] No | Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] Yes 2 [ ] No | |
| | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| E Quinn | D30641 | JANUARY 31, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAMESH SABHAPATHI 3400 ERDMAN AVE BALTIMORE MD. 21213

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 02 2001 | B. Sparks |

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04735

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Guy E Rinker

2. Date of Death (Month, Day, Year): January 29, 2001

3. Time of Death: 0837am

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 320-03-2035

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 9, 1910

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9701- VEIRS DRIVE

10f. Zip Code: 20850

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: UNKNOWN

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SERVICE REPRESENTATIVE

16b. Kind of Business/Industry: NOT AVAILABLE

17. Father's Name (First, Middle, Last): CHARLES LUTHER RINKER

18. Mother's Name (First, Middle, Maiden Surname): LULA WEATHERHOLTZ

19a. Informant's Name/Relationship (Type, Print): REV.DR. REICHARD-EXECUTOR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9701- VEIRS DR., ROCKVILLE, MD. 20850

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): NATIONAL MEMORIAL PARK | Date: 1/31

20c. Location - City or Town, State: FALLS CHURCH, VA.

21. Signature of Funeral Service Licensee: W. M. Hysong

22. Name and Address of Facility: Hysong Co., Inc. 6510- 16th St., NW, Wash., DC

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COPD Exacerbation — 3 days

Due to (or as a consequence of): b. Acute Bronchitis — 3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D56652

29d. Date signed (Month, Day, Year): JANUARY 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW POFFENROTH, MD 809 VIERS MILL RD, ROCKVILLE, MD

**State Registrar**

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04736

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GLADYS MARIE STALLINGS

2. Date of Death: Month 02 Day 02 Year 2001

3. Time of Death: 1244

4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 215 36 9497

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4-8-1922

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: PA

10b. County: Bedford

10c. City, Town or Location: Hyndman

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1645 Hyndman Road

10f. Zip Code: 15545

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Irvin Haldane Logsdon

18. Mother's Name (First, Middle, Maidan Surnama): Bessie Gertrude Beal

19a. Informant's Name/Relationship (Type, Print): Edgar W. Stallings, husband

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 1645 Hyndman Road, Hyndman, PA 15545

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar place): Palo Alto Hilltop Cemet. Date: 2-6-01

20c. Location - City or Town, Stata: Hyndman, PA

21. Signature of Funeral Service Licensee: Harvey H. Zeigler

22. Nama and Address of Facility: Harvey H. Zeigler Funeral Home, Hyndman, PA

**Physician /Medical Examiner**

23a. Part1. Enter the disaase, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yas 2☐ No

25. Wes case referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: Thomas E. Chapell MD

29c. Licansa number: D35135

29d. Date signed (Month, Day, Year): 2/5/01

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Thomas E. Chapell MD 912 Seton Dr Cumberland MD 21502

**State Registrar**

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

2 per Cerpio Rev MD

Amended #14, nls, 2/6/01, Allegany Co.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04737

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): VIOLET A. SMITH

2. Deta of Deeth: Month February Dey 2, Yaer 2001

3. Time of Death: 13:15

4e Facility Name (If not institution, give street and number): SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Deeth: ALLEGANY

**Funeral Director**

5. Social Security Number: 215-20-7064

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APR. 18, 1918

9. Birthplece (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: ALLEGANY

10c. City, Town or Location: LAVALE

10d. Insida City Limits: 1☐ Yas 2☒ No

10a. Street and Number: 11114 NEW YORK AVENUE, N.W.

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Merital Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, atc. Specify: ~~WITE~~ WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): ROBERT FORBECK

18. Mother's Name (First, Middle, Maiden Sumame): MARGARET ROBEY

19a. Informent's Name/Ralationship (Type, Pnint): JAMES SMITH / SON

19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 11114 NEW YORK AVE., NW, LAVALE, MD 21502

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cametary, crematory or othar place): RESTLAWN MEMORIAL GARDENS

Data: 2/05/2001

20c. Location - City or Town, Stata: LAVALE, MD

21. Signature of Funeral Service Licensee: Theresa A. Upchurch

22. Nama and Addrass of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions thet ceused the daeth. Do not entar the mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one ceuse on aech lina.

Approximate Intarval Batween Onsat and Death

Immediate Ceuse (Final disaase or condition resulting in death): e. CONGESTIVE HEART FAILURE — 2 YEARS

Dua to (or as e consequence of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 10 YEARS

Sequantially list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE; CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to complation of ceuse of death? 1☐ Yas 2☐ No

25. Wes cesa referred to medical examiner? 1☐ Yas 2☑ No

26. Place of Death (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be detarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the tima, date end place, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to tha ceuse(s) and manner stated.

29b. Signature and title of certifier: PHYSICIAN

29c. Licensa number: D50844

29d. Date signad (Month, Day, Year): February 2 ,2001

30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print): JOSE LOVERA JR., MD 912 SETON DRIVE CUMBERLAND, MD 21502

**State Registrar**

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

5 TMS

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04738

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Eugene William Stoner

2. Date of Death (Month, Day, Year): February 2 2001

3. Time of Death: 20:15

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 179-30-4539

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 5, 1937

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 106 Randolph Avenue Apt. 1

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maryland Metals

16b. Kind of Business/Industry: laborer

17. Father's Name *(First, Middle, Last)*: Irvin Stoner

18. Mother's Name *(First, Middle, Maiden Surname)*: Ella Mae Brisco

19a. Informant's Name/Relationship *(Type, Print)*: Lewis C. Stoner Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 606 Adams Avenue Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Rose Hill Cemetery

Date: 2/7/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich

22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street Hagerstown, Maryland 21740

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | ESOPHEAGEL CARCINOMA | 6M |
| Due to (or as a consequence of): b. | LUNG CANCER | 2M |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c. | PNEUMONIA | 1M |
| Due to (or as a consequence of): d. | DEEP VENIOUS THROMBOSIS | 1M |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FLUTTER

ALCOHOL ABUSE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D 52323

29d. Date signed *(Month, Day, Year)*: 2/3/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Waseem 19414 C Leitersburg Pike Hagerstown Maryland

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Eugene William Stoner

FEB 0 2 '00

01-0633-033
nmmnr
THOMAS SOUWEINE

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23,27,&28a-f per ME 0792 022901 SB

# Certificate of Death

Reg. No. 2001 04739

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thomas Joseph Souweine
2. Date of Death (Month, Day, Year): February 05, 2001
3. Time of Death: 1846 p M
4a. Facility Name (If not institution, give street and number): Bowie Health Center
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 213-60-2789
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 41 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 15, 1959
9. Birthplace (State or Foreign Country): New York

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 12317 Shelter Lane
10f. Zip Code: 20715
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Salesman
18b. Kind of Business/Industry: Direct sales

17. Father's Name (First, Middle, Last): Edward Leo Souweine
18. Mother's Name (First, Middle, Meiden Sumame): K. Rita McDermott

19a. Informant's Name/Relationship (Type, Print): Doris H. Souweine wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1712 Gunwood Place, Crofton, Md. 21114

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removel from State 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 02-07-01
20c. Location - City or Town, Stete: Alexandria, VA.

21. Signature of Funeral Service Licensee: ▶ Beall
22. Name and Address of Facility: Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. NARCOTIC INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as e consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnency: 1☐Live birth 2☐Fetel death 3☐Ectopic pregnency 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 1☒Yes 2☐No

**Medical Certification; To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day Year): found 2-5-01
28b. Time of Injury: found 6:00 PM
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: subject ingested drugs
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): unknown
28f. Location (Street end Number or Rural Route Number, City or Town, State): unknown

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es steted.
2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Stephen S. Radentz MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 06, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: ▶ Penny G. Sparks

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04740

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): PATRICIA JONES SAMUEL
2. Date of Death: Month JAN Day 30 Year 01
3. Time of Death: 2100
4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 578-88-3779
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 7, 1958
9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGE
10c. City, Town or Location: LANDOVER
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7711 WILLOW HILL DRIVE
10f. Zip Code: 20785
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4 YEARS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RECREATION SPECIALIST
16b. Kind of Business/Industry: PRESIDENTIAL WOODS NURSING HOME

17. Father's Name (First, Middle, Last): MAURICE B. JONES
18. Mother's Name (First, Middle, Maiden Surname): JOYCE M. HOWARD

19a. Informant's Name/Relationship (Type, Print): HASKER B. SAMUEL, III
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7711 WILLOW HILL DRIVE LANDOVER, MD 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FT. LINCOLN CEMETERY | Date: 2/6/01
20c. Location - City or Town, State: BRENTWOOD, MD

21. Signature of Funeral Service Licensee: Theodore C. Pinckney
22. Name and Address of Facility: PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH STREET, N. E. WASH., DC 20002

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. ANOXIC ENCEPHALOPATHY | 6 DAYS |
| Due to (or as a consequence of): | b. VENTRICULAR FIBRILLATION | 6 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. ACUTE MYOCARDIAL INFARCTION | 6 DAYS |
| Due to (or as a consequence of): | d. DIABETIC VASCULAR DISEASE | 7 YRS |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC RENAL FAILURE; DIABETIC RETINOPATHY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Tad Alloway. M.D.
29c. License number: D 28195
29d. Date signed (Month, Day, Year): 01-30-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID A. GOOLRAY, MD. 1450 MERCANTILE LANE. LARGO. MD. 20774

**State Registrar**

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death* Reg. No. 2001 04741

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Kim Leroy Scott
2. Date of Death Month Day Year: January 29, 2001
3. Time of Death: 11:40 P.M.
4a. Facility Name *(If not institution, give street and number)*: Mariner Health Care Center
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 579-88-9500
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 39 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 1/30/61
9. Birthplace *(State or Foreign Country)*: Wash.,D.C.

Usual Residence of Decedent

10a. State: D.C.
10b. County: N/A
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: # 62 Q Street, N.W.
10f. Zip Code: 20009
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes 2 ☐ No If Yes, Give Year or Dates: '80-'85
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Security Guard
16b. Kind of Business/Industry: Security
17. Father's Name *(First, Middle, Last)*: Leroy Scott
18. Mother's Name *(First, Middle, Maiden Surname)*: Carrie Washington
19a. Informant's Name/Relationship *(Type, Print)*: Carrie Lee/ Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 307 Heyse Ct.,Ft. Washington,Md. 20744
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cem. — Date: 2/2/01
20c. Location - City or Town, State: Washington,D.C.
21. Signature of Funeral Service Licensee: Gary W. Craft
22. Name and Address of Facility: H.S.Washington & Sons Co.,Inc. 4925 Burroughs Ave.,N.E.,Wash.,D.C. 20019

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MENINGITIS — Unknown
Due to (or as a consequence of):
b. PNEUMONIA — Unknown
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. HUMAN IMMUNO Deficiency Syndrome Unknown
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Arastoo Yazdani
29c. License number: D50454
29d. Date signed *(Month, Day, Year)*: January 31, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arastoo Yazdani,M.D. 11418 Livingston Rd.,Ft. Washington,Md. 20744

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04742

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MOSES SETTLES
2. Date of Death: Month 1 Day 25 Year 2001
3. Time of Death: 0742
4a. Facility Name (If not institution, give street and number): Prince George's Hosp Center
4b. City, Town, or Location of Death: Cheverly MD
4c. County of Death: PG

**Funeral Director**

5. Social Security Number: 579-78-9260
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 42 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 1, 1958
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Geroge's
10c. City, Town or Location: Capitol Heights
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 6213 Field St.
10f. Zip Code: 20743
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): James E. Settles
18. Mother's Name (First, Middle, Maiden Surname): Ruby Peterson

19a. Informant's Name/Relationship (Type, Print): Luther Settles/Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6213 Field St. Capitol Heights, MD 20743

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Cemetery
Date: 01/31/01
20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: Barbara J. Jenkins
22. Name and Address of Facility: J.B. Jenkins Funeral Home, 7474 Landover Rd. Landover, MD 20785

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Respiratory Failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Pneumonia
Due to (or as a consequence of):
c. CHF
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T.A. Matin MD
29c. License number: D05720
29d. Date signed (Month, Day, Year): 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3001 Hospital Dr Cheverly MD Terri A. Matin MD

**State Registrar**

31. Date filed (Month, Day, Year): JAN 29 2001
32. Registrar's Signature: Geneva B. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04743

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Rose Square

2. Date of Death — Month: January Day: 16 Year: 2001

3. Time of Death: 7:15AM

4a. Facility Name *(If not institution, give street and number)*: Garrett County Memorial Hospital

4b. City, Town, or Location of Death: Oakland

4c. County of Death: Garrett

**Funeral Director**

5. Social Security Number: 579-42-7918

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 13, 1933

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Garrett

10c. City, Town or Location: Oakland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 706 East Adler Street

10f. Zip Code: 21550

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* African American

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 8th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeper

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Bennie R. Square

18. Mother's Name *(First, Middle, Maiden Surname)*: Jennie D. Blount

19a. Informant's Name/Relationship *(Type, Print)*: Jennie E. Williams - Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2237 - 13th St., N.E. Wash., D.C. 20018

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lincoln Memorial Cem.

Date: 1/23/2001

20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Atherosclerotic Cardiovascular Disease — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Walter K. Naumann MD

29c. License number: D0025759

29d. Date signed *(Month, Day, Year)*: January 24, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Walter K. Naumann MD. PO Box 247 Accident MD 21520

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Geraldine D. Sparks

DHMH 16 Rev 6/95

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**To be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

1

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04744

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Mary E. Stewart
2. Data of Death Month / Day / Year: Jan 28 2001
3. Tima of Daath: 12:10 AM
4a Facility Nama *(If not institution, giva street and number)*: Civista Medical Center
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles

**Funeral Director**

5. Social Security Number: 579-48-9618
6. Sax: 1☐ M 2☒ F XX
7. Aga *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: Dec.13, 1910
9. Birthplaca *(Stata or Foraign Country)*: Washington,DC

Usual Rasidence of Decedant

10a. Stata: DC
10b. County:
10c. City, Town or Location: Washington, D.C.
10d. Insida City Limits: 1☒ Yas 2☐ No XX
10e. Street and Number: 2400 32nd St. S.E.
10f. Zip Coda: 20020
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed X 4☐ Divorced
12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No X — If Yas, Giva Yaar or Datas:
13. Was Decadant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No X *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decadant's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): 12th | Collaga (1-4or 5+):
16a. Decadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Housewife
16b. Kind of Businass/Industry: At Home

17. Fathar's Nama *(First, Middla, Last)*: Edward A. Hayden
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Cora Cash

19a. Informant's Name/Ralationship *(Type, Print)*: Mary Jane Murphy/Daughter
19b. Mailing Address *(Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda)*: 510 Chestnut Court LaPlata, Md. 20646

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Cedar Hill Cemetery
Data: 1/31/01
20c. Location - City or Town, Stata: Suitland, Md.

21. Signatura of Funaral Sarvica Licensaa: George P. Kalas
22. Nama and Addrass of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that ceusad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina. — Approximata Intarval Batween Onsat and Daath

Immediata Causa (Final disaasa or condition resulting in daath)
a. CONGESTIVE HEART FAILURE
Dua to (or as a consaquance of):
b. MITRAL REGURGITATION

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated evants resulting in daath) Last
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.: CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings availabla prior to compliation of causa of daath? 1☐ Yas 2☒ No

25. Was cesa rafarrad to medical axaminar? 1☐ Yas 2☒ No
26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*
27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Streat and Numbar or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar statad.
29b. Signatura and tita of cartifiar: MD
29c. Licansa number: D-53885
29d. Data signed *(Month, Day, Yaar)*: 1/28/2001

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): Venkat S Ramanan,MD 6 Post Office Road Suite 101 Waldorf,MD 20602

**State Registrar**

31. Data filed *(Month, Day, Yaar)*: JAN 30 2001
32. Registrar's Signatura: J. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: Tha law requiras that tha daath cartificata be executed within 24 hours after daath.

To the Funaral Director: Aftar this cartificata has been signed by tha attanding physician and complataly filled in by tha funaral director, paga 2 should be datachad for usa as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

STEWART, MARY

10

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04745

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Florence L. Smith

2. Date of Death (Month, Day, Year): January 28, 2001

3. Time of Death: 3:23 PM

4a. Facility Name (If not institution, give street and number): 920 White Oak Drive

4b. City, Town, or Location of Death: Oxon Hill

4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 170-50-4093

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 100 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 3, 1900

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Oxon Hill

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 920 White Oak Drive

10f. Zip Code: 20745

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: in Home

17. Father's Name (First, Middle, Last): Hurley Baylor

18. Mother's Name (First, Middle, Maiden Surname): Emily Alcock

19a. Informant's Name/Relationship (Type, Print): Beatrice Antonini-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as item #10

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Cemetery

Date: 02/02/01

20c. Location - City or Town, State: Milton, Pennsylvania

21. Signature of Funeral Service Licensee: Geo P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardiorespiratory Arrest

Due to (or as a consequence of):

b. Terminal Bladder Ca.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HTN.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) HOSPICE

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) —

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier: Sudha Sikri MD.

29c. License number: MD-D51462

29d. Date signed (Month, Day, Year): 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. SIKRI MD. 6357 Oxon Hill Road, Oxon Hill, MD. 20745

**State Registrar**

31. Date filed (Month, Day, Year): JAN 30 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04746

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Frances G. Stevens

2. Date of Death — Month: February; Day: 8; Year: 2001

3. Time of Death: 1426

4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

**Funeral Director**

5. Social Security Number: 216-30-8326

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Jun 30, 1934

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Caroline

10c. City, Town or Location: Preston

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3239 Gallager Road

10f. Zip Code: 21655

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Henry W. Colvin

18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Lillian Keener

19a. Informant's Name/Relationship *(Type, Print)*: Edward Stevens, Sr./Spouse

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3239 Gallager Rd., Preston, MD 21655

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Cem.

Date: 02/12/01

20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Michael J. Eskow

22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 48 hrs

Immediate Cause (Final disease or condition resulting in death)

a. respiratory failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. chronic obstructive lung disease

Due to (or as a consequence of):

c. coronary heart failure

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

upper gastrointestinal bleed

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: H55274

29d. Date signed *(Month, Day, Year)*: 2/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeaninne M. Einfalt, D.O., 219 S. Washington, Easton, MD 21601

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 09 2001

32. Registrar's Signature: Geneva G. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Frances Stevens

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04747

GEORGE TEDERICK 214-05-4094
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): George Howard Tederick
2. Date of Death (Month, Dey, Year): FEBRUARY 4 2001
3. Time of Death: 8:15 AM
4a. Facility Neme (If not institution, give street and number): Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

**Funeral Director**

5. Social Security Number: 214-05-4094
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): Oct 22, 1909
9. Birthplace (Stete or Foreign Country): MD

Usual Residence of Decedent

10a. Stete: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 121 Hanover Street
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yeer or Detas:
13. Was Decadent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify:
14. Race - American Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elemantery/Secondery (0-12): 12 | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Judge
16b. Kind of Business/Industry: Orphans' Court

17. Father's Neme (First, Middle, Last): George U. Tederick
18. Mother's Name (First, Middle, Maiden Surneme): Ida (Valentine)

19a. Informant's Neme/Reletionship (Type, Print): Juanita Hutton niece
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 303 Old Baltimore Road;Winchester VA 22603

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Rose Hill Cemetery
Dete: 2/06/2001
20c. Location - City or Town, Stete: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Nama and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

**Physician /Medical Examiner**

23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert fellure. List only one cause on eech line. — Approximata Interval Batween Onset end Death

Immediate Causa (Final diseasa or condition resulting in death): a. Acute Myocardial Infarction — 5 days
Dua to (or as e consequenca of):

Sequantially list conditions, if any, leading to immedieta cause. Enter Underlying Cause (Disaese or injury thet initieted events resulting in deeth) Last:
b.
Due to (or es e consequanca of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to compiation of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Hema 5☐ Rasidance 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined
28a. Data of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, data end plece, end due to the ceuse(s) and mannar steted.

29b. Signeture end title of certifier
29c. License number: D0033280
29d. Date signed (Month, Dey, Year): FEBRUARY 6, 2001

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): DR. SUNIL GUPTA, JOHNSON HEIGHTS MEDICAL BLDG., 625 KENT AVE., CUMBERLAND, MD 21502

**State Registrar**

31. Dete filed (Month, Dey, Year): FEB 06 2001
32. Registrer's Signature

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04748

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HOWARD THOMPSON
2. Date of Death: Month JANUARY Day 30 Year 2001
3. Time of Death: 1254
4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

**Funeral Director**

5. Social Security Number: 214-09-0056
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec.10,1908
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Boonsboro
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 143 S. Main Street
10f. Zip Code: 21713
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: XXX
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): 2 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): owner/retailer
16b. Kind of Business/Industry: Appliance Sales

17. Father's Name (First, Middle, Last): James E. Thompson
18. Mother's Name (First, Middle, Maiden Surname): Gertrude May Phillips

19a. Informant's Name/Relationship (Type, Print): James G. Thompson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20229 Rohrersville School Rd. Rohrersville,

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Boonsboro Cemetery | Date: Feb.2, 2001
20c. Location - City or Town, State: Boonsboro, MD

21. Signature of Funeral Service Licensee: Douglas A. Fiery
22. Name and Address of Facility: Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. MASSIVE SPONTANEOUS INTRACEREBRAL HEMORRHAGE ~4 DAYS.
Due to (or as a consequence of):
b. CEREBRAL HYPERTENSION
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D51043
29d. Date signed (Month, Day, Year): 1/31/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D. CARUSO MD 1150 PROFESSIONAL COURT HAGERSTOWN MD 21742

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

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Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Thompson, HOWARD

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 0479

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BRIAN EDWARD THOMPSON

2. Date of Death Month Dey Yeer: February 5 2001

3. Time of Death: 0050

4a. Facility Name (If not institution, give street end number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington County

**Funeral Director**

5. Social Security Number: 217-64-9688

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthdey): 44 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Aug. 14, 1956

9. Birthplece (State or Foreign Country): District of Col.

Usuel Residence of Dacedant

10a. Stete: MD

10b. County: Washington Co.

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 125 N. Prospect Street

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elemantery/Secondary (0-12): 12; College (1-4or 5+): 1

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Counselor

16b. Kind of Businass/Industry: Mission

17. Fether's Name (First, Middle, Last): James P. Thompson

18. Mother's Name (First, Middle, Maidan Surneme): Consuella Finks

19a. Informant's Neme/Relationship (Type, Print): James P. Thompson/Father

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 905 Othman Drive, Ft. Washington, MD 20744

20a. Method of Disposition: 1☐ Buriet 2☒ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Othar (Specify)

20b. Ptace of Disposition (Neme of cemetery, cremetory or other piece): Smithsburg Crematory

Data: Feb. 6

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signeture of Funeral Service Licensee: Douglas A Fiery

22. Name end Address of Fecility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21742

**Physician /Medical Examiner**

23a. Part1. Entar tha disaase, or complicetions that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiretory errest, shock, or haert failura. List only one ceuse on eech lina.

Approximete Interval Batween Onset end Death

Immediete Causa (Final disease or condition resulting in deeth)

a. A. I. D. S. — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due fo (or es e consequence of):

d.

Pert It. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Descnbe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at the time, dete end plece, end due to tha causa(s) and manner es steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigetion, in my opinion, daath occurred at tha time, data end placa, and dua to the causa(s) end mannar stated.

29b. Signeture end title of certifier: Dan H. McDougal MD

29c. License number: D21470

29d. Date signed (Month, Day, Yeer): 2/5/01

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dr. McDougal 11110 Medical Campus Rd Hag. Md. 21742

**State Registrar**

31. Dete filed (Month, Dey, Yeer): FEB 06 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Brian Thompson

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Funeral Director**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 04750

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lois Jean Toms
2. Date of Death: Month February Day 4, Year 2001
3. Time of Death: 8:15 P.M.
4a. Facility Name (If not institution, give street and number): 13913 Ridenour Rd.
4b. City, Town, or Location of Death: Smithsburg
4c. County of Death: Frederick

**Funeral Director**

5. Social Security Number: 171-28-7743
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 23, 1932
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Md.
10b. County: Frederick
10c. City, Town or Location: Smithsburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13913 Ridenour Rd.
10f. Zip Code: 21783
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): David Calvin Stiffler
18. Mother's Name (First, Middle, Maiden Surname): Ada Grace Robinette

19a. Informant's Name/Relationship (Type, Print): Clyde R. Toms (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13913 Ridenour Rd. Smithsburg, Md. 21783

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Mt. Bethel Cemetery | Date: Feb. 7, 2001
20c. Location - City or Town, State: Foxville, Md.

21. Signature of Funeral Service Licensee: Dennis R. Davis
22. Name and Address of Facility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. BREAST CANCER | ONE YEAR |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D43590
29d. Date signed (Month, Day, Year): 2/6/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN PERD 22911 Jefferson BLVD SMITHSBURG MD, 21783

**State Registrar**

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04751

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Frederick Alfred Thorne | Jan 30 2001 | 735 Am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 13839 Greenfield St. | Maugansville | Washington |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-66-9898 | 1☒ M 2☐ F | 84 Yrs. | | | August 9, 1916 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Washington | Maugansville | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 13839 Greenfield St. | 21760 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 0 | | Disabled | not applicable |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Thorne | Julia Coxen |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jacqueline Meyer/Niece | 7200 Popkins Farm Rd., Alexandria, VA 22306 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify) | Providence United Methodist Church Cemetery | 02/02/01 | Ft. Washington, MD |

21. Signature of Funeral Service Licensee: George P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Congestive heart Failure | |
| Due to (or as a consequence of): | b. Coronary Artery Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Atherosclerosis | |
| Due to (or as a consequence of): | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Group Home |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Frederick L Kass III MD | D23623 | January 30, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
F. L. Kass III MD 11110 medical Campus Rd Hagerstown Md 21742

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 02 2001 | D. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04752

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MITSUKO NMN TANG
2. Date of Death Month Day Year: JANUARY 23, 2001
3. Time of Death: 9:55AM
4a. Facility Name *(If not institution, give street and number)*: NATIONAL INSTITUTE OF HEALTH
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

**Funeral Director**

5. Social Security Number: 415-31-7887
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT 5, 1949
9. Birthplace *(State or Foreign Country)*: JAPAN

Usual Residence of Decedent

10a. State: VA.
10b. County: FAIRFAX
10c. City, Town or Location: BURKE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5812 CANVASBACK ROAD
10f. Zip Code: 22015
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* ASIAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: NABEZO UEZU
18. Mother's Name *(First, Middle, Maiden Surname)*: TAKE UEHARA

19a. Informant's Name/Relationship *(Type, Print)*: ANTHONY M. TANG - HUSBAND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5812 CANVASBACK ROAD, BURKE, VIRGINIA 22015

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: NATIONAL CREMATORY
Date: 1/27/01
20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee: ▶ Richard G. Lamporte
22. Name and Address of Facility: DEMAINE FUNERAL HOME, 520 S. WASHINGTON ST., ALEXANDRIA, VA 22314

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIOPULMONARY ARREST

Due to (or as a consequence of):
b. ADULT T-CELL LYMPHOMA — 1993

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. ANEMIA, GRANULOCYTOPENIA, THROMBOCYTOPENIA

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶
29c. License number: NYS 156395
29d. Date signed *(Month, Day, Year)*: 1-25-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JOHN MORRIS MD 9000 ROCKVILLE PIKE BETHESDA MD 20892

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: ▶ for B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

(6)

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04753

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Charles A. Thomas, Sr.

2. Date of Death: Month January Day 27 Year 2001

3. Time of Death: 3:52AM

4a. Facility Name (If not institution, give street and number): Doctor's Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 215-26-3602

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): Feburary 24, 1932

9. Birthpiece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7428 Belhaven Ct.

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Accident Investigator

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Joseph Thomas

18. Mother's Name (First, Middle, Maiden Surname): Mary Payne

19a. Informant's Name/Relationship (Type, Print): Cecilia Thomas/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7428 Belhaven Ct. Landover, MD 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony

Date: 02/02/01

20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

**To Be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metabolic acidosis & Sepsis

Due to (or as a consequence of):
b. Terminal prostate Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Severe Bronchitis

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mehru Master Snyder MD

29c. License number: D050514

29d. Date signed (Month, Day, Year): 1/29/01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mehru Master Snyder MD 6510 Icenilworth ave. Suite 210, Riverdale, MD 20737

**State Registrar**

31. Date filed (Month, Dey, Year): FEB 01 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04754

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Gilda | C. | Wilfong | January 31, 2001 | 12:10 P.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Memorial Hospital & Medical Center | Cumberland | Allegany |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-24-6444 | 1☐M 2☒F | 71 Yrs. | | | Apr 28, 1929 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Allegany | Cumberland | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 138 W. Third Street | 21502 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☐No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | homemaker | own home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John Arbogast | Gay (Nixon) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John G. Wilfong husband | 138 W. Third Street;Cumberland MD 21502 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Scarpelli Funeral Home | 2/01/2001 | Cresaptown, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ James J Scarpelli | Scarpelli Funeral Home, P.A. Cumberland, MD 21502 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | 4 hours |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D0033280 | Jan 31, 2001 |

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Sunil K. Gupta 625 Kent Avenue Cumberland, MD 21502

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 01 2001 | ▶ Geneva B Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Physician /Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4

MD

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04755

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Edwin Virgil WILLIAMS

2. Date of Death — Month: January Day: 28 Year: 2001

3. Time of Death: 1649

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 214-09-9586

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 2,1917

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 15106 Bloyers Avenue

10f. Zip Code: 21740

10g. Citizen of Whet Country?: USA

11. Merital Stetus: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U,S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yaer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 — College (1-4or 5+): 0

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: signalman

16b. Kind of Business/Industry: railroad

17. Fethar's Nema *(First, Middla, Last)*: Grover C. Williams

18. Mother's Nama *(First, Middla, Maiden Surnama)*: Mary Kate Gruber

19a. Informent's Neme/Reletionship *(Type, Print)*: Coleen Ferguson - daughter

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 7870 WNC Highway 10, Vale, N.C. 28168

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Rest Haven Cemetery — Dete: 2-2-01

20c. Location - City or Town, State: Hagerstown,Maryland

21. Signatura of Funeral Service Licensee: Scott Minnich

22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E.Wilson Blvd.,Hagerstown, Md. 21740

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disaase or condition resulting in deeth)

a. Acute Myocardial Infarction — 1 hr.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. ATHEROSCLEROSIS

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contribute to the causs of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and pleca, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date end pleca, end due to the cause(s) and manner steted.

29b. Signature and title of certifier: H Dear, M.D.

29c. License number: D46561

29d. Dete signed *(Month, Day, Year)*: JAN 30. 2001.

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Dr. Qadir 20311 Lappans Rd Boonsboro, Md. 21713

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: Brenda B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Williams, Edwin

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04756

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Earl Leslie WOLFF, Jr.

2. Date of Death: Month Jan Day 30 Year 2001

3. Time of Death: 7:10 AM

4a. Facility Name (If not institution, give street and number): 14113 Stoneridge Lane

4b. City, Town, or Location of Death: Maugansville

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 184-12-3320

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Sept. 23 1921

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Washington | 10c. City, Town or Location: Maugansville | 10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14113 Stoneridge Lane | 10f. Zip Code: 21767 | 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Army Depot

17. Father's Name (First, Middle, Last): Earl Leslie Wolff, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary Alice Creager

19a. Informant's Name/Relationship (Type, Print): June A. Wolff - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14113 Stoneridge Lane Maugansville, Md. 21767

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, cramatory or other place): Rest Haven Cemetery | Date: 1/31/2001

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: James L. Spiers

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. acute lymphoma — months

Due to (or as a consequence of):
b. arteriosclerotic heart disease & failure — yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. acute renal failure — weeks

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harold R Tritch Jr MD

29c. License number: D0012194

29d. Date signed (Month, Day, Year): Jan 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HAROLD R TRITCH JR MD 348 Hall ST HAGERSTOWN MD 21740

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04757

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Barbara Jean Weese
2. Date of Death — Month: 02 Day: 01 Year: 2001
3. Time of Death: 3:30 P.M.
4a. Facility Name *(If not institution, give street and number)*: 437 Ridge Avenue
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 213-42-1608
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/31/1941
9. Birthplace *(State or Foreign Country)*: Hagerstown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 437 Ridge Avenue
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Years — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nursing Assistant
16b. Kind of Business/Industry: State Hospital

17. Father's Name *(First, Middle, Last)*: Arthur Hartle
18. Mother's Name *(First, Middle, Maiden Surname)*: Pauline Miller

19a. Informant's Name/Relationship *(Type, Print)*: Ray L. Weese, Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 441 Ridge Ave., Hagerstown, MD 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery — Date: 02/05/2001
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: P. Steven Danfelt, Jr. P. Steven Danfelt, Jr.
22. Name and Address of Facility: Rest Haven Cemetery 1601 Pennsylvania Avenue Hagerstown, MD 21742

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiac Arrythmias — 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure; Diabetes Mellitus type II; Obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [illegible] MD
29c. License number: D74827
29d. Date signed *(Month, Day, Year)*: 2/2/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Allen Chery MD, 12821 Oakehill Ave, Hagerstown MD 21742

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 05 2001
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04758

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ADDIE MARIE WHITE
2. Date of Death (Month, Day, Year): January 29 2001
3. Time of Death: 10:45 a.m.
4a. Facility Name (If not institution, give street and number): Wicomico Nursing Home
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 214-10-6443
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 23, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 900 Booth Street
10f. Zip Code: 21804
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): –
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): George Handy Wilkins
18. Mother's Name (First, Middle, Maiden Surname): Mary Ellen Griffin

19a. Informant's Name/Relationship (Type, Print): Rev. Melvin L. White/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 116 Naylor St., Salisbury, MD 21804

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Wicomico Memorial Park
Date: 2/3/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: David M. Thompson M01051
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. METASTATIC Carcinoma

Due to (or as a consequence of):
b. Breast cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: Scott M
29c. License number: D34145
29d. Date signed (Month, Day, Year): 1/30/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Rifkin 11 Aston Ct Owings Mills, MD 21117

**State Registrar**

31. Data filed (Month, Day, Year): FEB 0 1 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

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Addie White

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

6 DQ

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04759

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ida Marie Ward

2. Date of Death (Month, Day, Year): January 31, 2001

3. Time of Death: 10:00 AM

4a. Facility Name *(If not institution, give street and number)*: Salisbury Center: Genesis ElderCare

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

**Funeral Director**

5. Social Security Number: 212-10-2669

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 5-21-1914

9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Wicomico

10c. City, Town or Location: Hebron

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 27208 OceanGateway

10f. Zip Code: 21830

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Shirt Factory

16b. Kind of Business/Industry: Garment

17. Father's Name *(First, Middle, Last)*: Henry Phippin

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Bailey

19a. Informant's Name/Relationship *(Type, Print)*: Bernice Taylor daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O.Box513 Hebron, Md. 21830

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Springhill Memory Gardens cemetery

Date: 2-3-01

20c. Location - City or Town, State: Hebron, Md.

21. Signature of Funeral Service Licensee: [signature] moo416

22. Name and Address of Facility: Messick Funeral Home P.O. Box 61 Bivalve, Md. 21814

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute + Chronic Renal Failure

Due to (or as a consequence of):

b. Sepsis — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Advanced Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D59813

29d. Date signed *(Month, Day, Year)*: 1/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael R. Atkins, M.D. 1104 Healthway Dr., Salisbury, MD 21804

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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Ida M. Ward
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04760

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Gloria R. Wilson
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 11:55am
4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 579-24-6741
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 7, 1929
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: New Carrollton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6113 Westbrook Dr.
10f. Zip Code: 20784
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: U.S. Coast Guard Worker
16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Unk
18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Mae Bell

19a. Informant's Name/Relationship *(Type, Print)*: Warner H. Wilson, Jr.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6113 Westbrook Dr. New Carrollton, Md. 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery
Date: 2/3/01
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: Keith A. Harvey M0185
22. Name and Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disaase or condition resulting in death)
a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Cerebrovascular Accident

Dua to (or as a consequence of):
c. Urosepsis

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Myocardial Infarction; Electrolyte Imbalance

23b. Did tobacco uss contributs to the causs of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yes 2☐ No

25. Was case rafarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P Saujla MD Attending.
29c. License number: D42580
29d. Date signed *(Month, Day, Year)*: January 29, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): P. Saujla,M.D.5632 Annapolis Rd. #13 Bladensburg, Md. 20710

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 01 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04761

Amend # 18. Per FH PGC 2-12-01 cr

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Dete of Deeth Month | Dey | Year | 3. Time of Deeth |
|---|---|---|---|---|
| Thelma B. Wells | 01 | 26 | 2001 | 11:00 PM |

| 4e Feciility Neme (If not institution, give street end number) | 4b. City, Town, or Location of Deeth | 4c. County of Deeth |
|---|---|---|
| Ft Washington Medical Center | Ft Washington | Prince George's |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Yeer: Months | Deys | If Under 24 Hrs.: Hours | Min. | 8. Dete of Birth (Month, Dey, Yeer) | 9. Birthplece (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 270-12-0440 | 1☐ M 2☒ F | 79 Yrs. | | | | | 8-21-1921 | Pennsylvania |

Usuel Residenca of Decedent

| 10a. Stete | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Prince George's | Bowie | 1☒ Yes 2☐ No |

| 10e. Street end Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 15607 Everglade Lane #303 | 20716 | U.S.A. |

| 11. Maritel Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Bleck, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Yeer or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grede completed) | | 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| | 2yrs | Transportation Analyst | Government |

| 17. Fether's Neme (First, Middle, Last) | 18. Mother's Neme (First, Middle, Meiden Sumeme) |
|---|---|
| Clarence N. Brown | Daisie ~~Dorsie~~ Wilson |

| 19e. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Dianne E. Hargust/Niece | 15607 Everglade Lane Bowie, MD 20716 |

| 20e. Method of Disposition | 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒ Buriel 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify) | Maryland Veterans Cemetery | 1-31-01 | Cheltenham, MD |

| 21. Signature of Funeral Service Licensee | 22. Name end Address of Facility |
|---|---|
| ▶ | J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785 |

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Final diseese or condition resulting in death)
e. Pneumonia

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest
b.

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ ~~Unknown~~

| 24e. Wes en eutopsy performed? | 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Wes case referred to medical exeminer? | 26. Piece of Deeth (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify) |

| 27. Menner of Death | 28a. Date of Injury (Month, Dey Yeer) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ ~~Nature~~l 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ ~~Certifying~~ Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner steted.

| 29b. Signature end title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Yeer) |
|---|---|---|
| ▶ Michael Pimentel, DO | MD H00042445 | January 27, 2001 |

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Michael Pimentel, DO
601 Post office Road, 1-A Waldorf, MD 20602

**State Registrar**

| 31. Dete filed (Month, Day, Year) | 32. Registrer's Signature |
|---|---|
| JAN 29 2001 | ▶ G. Sparks |

DHMH 16 Rev 6/95

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

01-0321-510
mnmr
Norman Williams Sr.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04762

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Norman Williams
2. Date of Death (Month, Day, Year): January 19, 2001
3. Time of Death: 1855 pm
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 243-68-9865
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 24, 1943
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4218 Loch Raven Blvd.
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Private Company

17. Father's Name (First, Middle, Last): Thelmon Williams
18. Mother's Name (First, Middle, Maiden Surname): Ruby Starfield

19a. Informant's Name/Relationship (Type, Print): Delores Williams (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1106 Milton Ave. Baltimore, Md.

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 1-27-01
20c. Location - City or Town, State: Landsdowne, Md.

21. Signature of Funeral Service Licensee: Leander M. Coles
22. Name and Address of Facility: Tri-State F/S/ 108 W.North Ave. Baltimore, Md.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ~~Arteriosclerotic Cardiovascular Disease~~

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? Inspection 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Pestaner, M.D
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)

**State Registrar**

31. Date filed (Month, Day, Year): JAN 30 2001
32. Registrar's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04763

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret Washington

2. Date of Death (Month, Day, Year): January 25, 2001

3. Time of Death: 1115 pm

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

**Funeral Director**

5. Social Security Number: 214 76 5249

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 31, 1912

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 501 West Franklyn St.

10f. Zip Code: 21201

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 8th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Private(own home)

17. Father's Name (First, Middle, Last): James H. Washington

18. Mother's Name (First, Middle, Maiden Sumeme): Cora Tate

19a. Informant's Neme/Reletionship (Type, Print): Mildred Sumiel/niece

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 501 West Franklyn St. Baltimore, MD 21201

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): New Zion Bapt. Church Cem.

Dete: 1-31-01

20c. Location - City or Town, Stete: Warsaw, Virginia

21. Signature of Funerel Service Licensee: ▶ Kimberly C Buscee-Tone

22. Name end Address of Fecility: Marshall's Funeral Home of MD, 4308 Suitland Road Suitland, MD 20746

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in deeth)

e. Arteriosclerotic Cardiovascular Disease

Due to (or es e consequence of):

b. Chronic Obstructive Pulmonary Disease

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Last

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospitel: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☑ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and pleca, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: ▶ Liaqat Ali

29c. License number: D47405

29d. Date signed (Month, Dey, Year): 1/26/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Liaqat Ali, M.D. 40 Maryland General Hospital

**State Registrar**

31. Date filed (Month, Dey, Year): JAN 30 2001

32. Registrar's Signature: ▶ G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Margaret Washington

DC

(2)

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04764

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY WARD

2. Dete of Deeth — Month: 01 / Day: 23 / Year: 2001

3. Time of Deeth: 1805

4a. Fecility Name (If not institution, give street and number): Prince Georges Hospital Center

4b. City, Town, or Location of Deeth: Cheverly

4c. County of Death: Prince Georges

**Funeral Director**

5. Social Security Number: 578-12-7834

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): October 21, 1912

9. Birthplece (State or Foreign Country): Washington, DC

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Riverdale

10d. inside City Limits: 1☐ Yes 2☒ No XX

10e. Street end Number: 5226 59th Ave.

10f. Zip Code: 20727

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced XX

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify:

14. Race - Americen Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 7 College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): John F. Ward

18. Mother's Name (First, Middle, Maiden Surname): Marie A. Baumann

19a. Informant's Neme/Relationship (Type, Print): Frederick Seegar / Son

19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 4010 Hallman St. Fairfax, VA 22030

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) X

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery

Dete: January 29,

20c. Location - City or Town, Stete: 2001 Brentwood, MD

21. Signature of Funeral Service Licensee: Boyd R Nelson

22. Neme and Address of Fecility: Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final diseese or condition resulting in deeth): a. Intracranial hemorrhage

Due to (or es a consequence of): b. ischemic stroke, hypertension,

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest

Due to (or as a consequence of): c.

Due to (or es e consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Parkinson disease, Alzheimer disease

23b. **Did tobacco use contribute to the cauee of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, date and piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D0054140

29d. Date signed (Month, Day, Year): 1/24/01

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): SHERVIN RAHMANI, M.D 3001 Hospital Drive Cheverly, MD 20785

**State Registrar**

31. Dete filed (Month, Day, Year): JAN 31 2001

32. Registrer's Signature: Jenny D. Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "neturel", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04765

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOYCE WILLIAMS
2. Date of Death Month: JAN Day: 25 Year: 2001
3. Time of Death: 6:55AM
4a. Facility Name (If not institution, give street and number): HOWARD CO. GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

**Funeral Director**

5. Social Security Number: 231-50-9437
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 2, 1940
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: TEXAS
10b. County:
10c. City, Town or Location: SAN ANTONIO
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 14735 HILLSIDE RIDGE
10f. Zip Code: 78233
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SCHOOL TEACHER
16b. Kind of Business/Industry: TEXAS SCHOOL SYSTEM

17. Father's Name (First, Middle, Last): ERNEST ROBB
18. Mother's Name (First, Middle, Maiden Surname): DOROTHY TURNER

19a. Informant's Name/Relationship (Type, Print): RICHARD WILLIAMS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14735 HILLSIDE RIDGE SAN ANTONIO, TEXAS 78233

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MOUNT LAUREL | Date: 1-29-01
20c. Location - City or Town, State: CAROLINA CO, VA

21. Signature of Funeral Service Licensee: Roger Mann
22. Name and Address of Facility: BAILEY FUNERAL SVC 1209 WHITE ST FREDERICKSBURG VA

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Pancreatic Carcinoma — months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Patryce Toye MD Deputy ME
29c. License number: D31473
29d. Date signed (Month, Day, Year): Jan 25, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRYCE A. TOYE, MD 4565 Hemlock Cone Way Ellicott City 21042

**State Registrar**

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

16

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04766

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Raymond Wills

2. Date of Death — Month: January Day: 27, Year: 2001

3. Time of Death: 6:00 PM

4a. Facility Name *(If not institution, give street end number)*: Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton, MD

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 578-09-7592

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 5-1-1908

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1906 Gaylord Dr

10f. Zip Code: 20746

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Minister

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Geary Wills

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillie Moreland

19a. Informant's Name/Relationship *(Type, Print)*: Alice B. Wills/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1906 Gaylord Dr Suitland, MD 20746

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Lothian Cemetery Church

Date: 2-3-2001

20c. Location - City or Town, State: Lothian, MD

21. Signature of Funeral Service Licensee: L B

22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Septic Shock.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Ulcerating foot infection

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dehydration, senile, s/p Cerebrovascular accident left hemiplegia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D20824

29d. Date signed *(Month, Day, Year)*: 1/29/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Glenn Duncan 9450 Penn. Ave. #18 Upper Marlboro MD 20772

**State Registrar**

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: P. Sparks

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

W, Ils, Raymond 1/27/01 6:00 pm YC

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04767

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Elizabeth Mary Yutzy

2. Date of Death (Month, Day, Year): February 1 2001

3. Time of Death: 13:50

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 217-10-4104

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: November 15, 1911

9. Birthplaca *(State or Foraign Country)*: Maryland

Usual Rasidance of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 11 W. Baltimore Street

10f. Zip Code: 21740

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Dacedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completad)*: Elamantery/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Receptionist

16b. Kind of Businass/Industry: Dr. Roger Fiery

17. Fathar's Nama *(First, Middla, Last)*: Arthur P. Mullooly

18. Mothar's Nama *(First, Middla, Maidan Sumame)*: Catherine E. Gray

19a. Informant's Name/Ralationship *(Type, Print)*: Jean A. Dorsey Cousin

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: P. O. Box 240 Ridgeley, West Virginia 26753

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cametary, crematory or other placa)*: Cedar Lawn Memorial Park

Data: 2/3/01

20c. Location - City or Town, Stata: Hagerstown, Maryland

21. Signatura of Funaral Sarvice Licensee: Gerald N. Mimich

22. Nama and Addrass of Facility: Gerald N. Mimich Funeral Home, 305 N. Potomac Street Hagerstown, Maryland 21740

**Physician /Medical Examiner**

23a. Part I. Enter the disaasa, or complications thet caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina.

Approximata Intarval Between Onsat and Death

Immediata Causa (Finel disaasa or condition resulting in death)
a. pneumonia — 7 days

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaese or Injury that initiated evants rasulting in death) Last
b.
Dua to (or as a consaquanca of):
c.
Due to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa given in Part I.: COPD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to complation of causa of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and place, and due to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and due to tha ceuse(s) and mannar stated.

29b. Signatura and titla of certifiar: William Hammerash MD

29c. Licansa number: D 0055926

29d. Data signed *(Month, Day, Year)*: 2/3/01

30. Name end addrass of person who completed causa of daath (Item 23a) (Type, Print): Dr. Hammerash 100 Geeting Lane Keedysville Maryland

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 05 2001

32. Registrer's Signeture

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Elizabeth Marie Yutzy

FEB 05 '96

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04768

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): Roger A. Zook

2. Dete of Deeth — Month: 02 Day: 03 Yeer: 01

3. Time of Deeth: 2110

4a. Facility Neme (If not institution, give street end number): M.D. Correctional Institution Hagerstown

4b. City, Town, or Location of Death: Wash

4c. County of Deeth

**Funeral Director**

5. Social Security Number: 215-38-5768

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): July 19, 1940

9. Birthpiece (Stete or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10a. State: Md.

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 9411 Boulder Rd.

10f. Zip Code: 21701

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Reca - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Lab Technician

16b. Kind of Business/Industry: Builders

17. Fether's Neme (First, Middle, Last): Ralph Ambrose Zook

18. Mother's Name (First, Middle, Meiden Surneme): Gladys Unknown

19e. Informent's Name/Relationship (Type, Print): J. Michael Resser (Friend)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): P.O. Box 265 Walkersville, Md. 21793-0265

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Brown Cemetery

Dete: Feb. 7, 2001

20c. Location - City or Town, State: Foxville, Md.

21. Signature of Funeral Servica Licensee: Dennis R. Davis

22. Name end Address of Feclity: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immedlete Ceuse (Final disease or condition resulting in death)

a. bil. Lung mass

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

b. C.O.P.D

Due to (or es e consequenca of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other eignificent conditions** contributing to death but not resulting in the underlying cause given in Part I.

hypertrophic cardiomegaly

23b. Did tobecco use contribute to the ceuee of deeth? 1 [ ] Yee 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Date of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Phyeicien**: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner**: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: Mohamed S. Moubarek MD

29c. License number: D0046549

29d. Date signed (Month, Dey, Yeer): 2/3/01

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): Mohamed S. Moubarek 18601 Baxbury Rd., Hag., Md. 21746

**State Registrar**

31. Date filed (Month, Dey, Yeer): FEB 07 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours eftar death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 04769

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| GEORGE A. L ALSTON | FEBRUARY 15, 2001 | 3:30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 1615 N. BOND STREET | BALTIMORE | BALTIMORE CITY |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-50-7038 | 1☒M 2☐F | 53 Yrs. | | | OCTOBER 3,1947 | VIRGINIA |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | BALTIMORE CITY | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1615 N. BOND STREET | 21213 | UNITED STATES |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☒Yes 2☐No If Yes, Give Year or Dates: 8/68-7/71 | 1☐Yes 2☒No Specify: | Specify: BLACK |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 1 | SCANNING ADMINISTRATOR | GROCERY |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Neme (First, Middle, Meiden Surneme) |
|---|---|
| ALBERT LEE ALSTON | ETHEL CUNNINGHAM |

| 19a. Informant's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| ALICE ALSTON-WIFE | 1615 N. BOND STREET, BALTIMORE, MARYLAND 21213 |

| 20a. Method of Disposition | 20b. Place of Disposition (Neme of cemetery, crematory or other piece) | Dete | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify) | LOUDON PARK CEMETERY | 2-19-01 | BALTIMORE, MARYLAND |

21. Signature of Funeral Service Licensee: Lisa S. Jefferson

22. Name and Address of Facility: LOUDON PARK FUNERAL HOME, 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC NEUROENDOCRINE TUMOR — 9 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Wes decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Auerbach MD
29c. License number: D33551
29d. Date signed (Month, Day, Year): Feb. 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael AUERBACH, 9000 FRANKLIN SQ Dr, Baltimore 21237

10+1

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Bernard G Brooks

DHMH 17 Rev 1/2001

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 01770

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): George Armacost

2. Date of Death Month: February Day: 14 Year: 2001

3. Time of Death: 6:20 PM

4a. Facility Name (If not institution, give street and number): 226 Dawson Drive

4b. City, Town, or Location of Death: Cockesyville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-07-2864

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6-20-14

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 226 Dawson Drive

10f. Zip Code: 21030

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): chief of scheduling

16b. Kind of Business/Industry: bethlehem steel

17. Father's Name (First, Middle, Last): George H. Armacost Sr

18. Mother's Neme (First, Middle, Meiden Surname): Edith Brown

19a. Informant's Name/Relationship (Type, Print): Catherine W. Armacost/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 226 Dawson Drive Cockeysville, MD 21030

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardio Vascular Disease

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles O'Donnell MD

29c. License number: D-09383

29d. Date signed (Month, Day, Yeer): February 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F. O'Donnell MD 111 Hamkt Hill Rd Baltimore Md 21210

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: Glenna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04771

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Eston Maine Allen

2. Date of Death Month / Day / Year: February 13, 2001

3. Time of Death: 12:28 am

4a. Facility Name *(If not institution, give street and number)*: 14624 Tulip Lane

4b. City, Town, or Location of Death: Hancock

4c. County of Death: Washington

**Funeral Director**

5. Social Security Number: 233-34-3740

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 31, 1924

9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Hancock

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14624 Tulip Lane

10f. Zip Code: 21750

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Pile Driver

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Virgil Donovan Allen

18. Mother's Name *(First, Middle, Maiden Surname)*: Lucinda Ellen Gaither

19a. Informant's Name/Relationship *(Type, Print)*: Doris L. Allen/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14624 Tulip Lane Hancock, MD 21750

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Nebo Cemetery

Date: 02/15/01

20c. Location - City or Town, State: Great Cacapon, WV

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COPD — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Frank B Thomas III M.D.

29c. License number: D0012237

29d. Date signed *(Month, Day, Year)*: 2/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANK B THOMAS III M.D. 2 TONOLOWAY St HANCOCK, MD 21750

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04772

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DOROTHY ANDERSON

2. Date of Death — Month: FEBRUARY Day: 18 Year: 2001

3. Time of Death: 3:17 AM

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212-20-3899

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT 28, 1925

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD. 10b. County: BALTIMORE 10c. City, Town or Location: DUNDALK 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 814 SOUTH 50th ST. 10f. Zip Code: 21222 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 8th — College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): FRANCIS J. SKALINSKI

18. Mother's Name (First, Middle, Maiden Surname): FRANCES A. BUCZEK

19a. Informant's Name/Relationship (Type, Print): JAMES ANDERSON - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7428 OLD BATTLE GROVE RD. BALTO. MD. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SACRED HEART OF MARY Date: 2/22/01

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Anthony C. Connelly

22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point RD. BALTO. MD 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — ONE WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

ACUTE PANCREATITIS

GASTROINTESTINAL BLEED

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Raphael Dodoo P 12557

29c. License number: P 12557

29d. Date signed (Month, Day, Year): FEBRUARY 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAPHAEL DODOO 5607 LOCH RAVEN BLVD, BALTIMORE MD 21239

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04773

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILLIAM FRANK ADAMS JR.
2. Date of Death (Month, Day, Year): FEB 18 2001
3. Time of Death: 1:00 AM
4a. Facility Name (If not institution, give street and number): 6436 POLK CL
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 213-28-1265
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT 15, 1932
9. Birthplace (State or Foreign Country): MD.

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD.
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6436 Polk CL.
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TAXI DRIVER
16b. Kind of Business/Industry: AIRPORT

17. Father's Name (First, Middle, Last): WILLIAM F. ADAMS SR.
18. Mother's Name (First, Middle, Maiden Surname): AGNES SIMINSKI

19a. Informant's Name/Relationship (Type, Print): JANELLE ADAMS - WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6436 Polk CL. Glen Burnie, MD. 21060

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SACRED HEART of MARY
Date: 2/19/01
20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Anthony C. Connelly
22. Name and Address of Facility: Connelly Funeral Home of Arundel, P.A. 7110 Stella Print. Rd. Balto. MD 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Lung Cancer — 4 Months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Markman M.D
29c. License number: D39505
29d. Date signed (Month, Day, Year): February 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Yndhish Markman 1600 Crain Hwy #602, Glen Burnie MD. 21061

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: D Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04774

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Carol L. Alexander
2. Date of Death (Month, Day, Year): Feb. 17, 2001
3. Time of Death: 8:30 A M
4a. Facility Name (If not institution, give street and number): 13825 Manor Road
4b. City, Town, or Location of Death: Baldwin
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-90-5973
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 36 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 15, 1964
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Baldwin
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 13825 Manor Road
10f. Zip Code: 21013
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Refuge

17. Father's Name (First, Middle, Last): George R. Albright
18. Mother's Name (First, Middle, Maiden Surname): Doris J. Thompson

19a. Informant's Name/Relationship (Type, Print): Mr. John R. Alexander, Jr./Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13825 Manor Rd. Baldwin, Maryland 21013

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Clynmalira Cemetery
Date: 2/21/01
20c. Location - City or Town, State: Phoenix, Maryland

21. Signature of Funeral Service Licensee: Michael J. Ruck Jr.
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Glioblastoma Multiforme — 1yr 4months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Yeer

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☐No
26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.
29b. Signature and title of certifier: Ruth Kantor M.D.
29c. License number: D28594
29d. Date signed (Month, Day, Yeer): 2/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ruth Kantor M.D. 6569 North Charles St. Suite 210 Towson, Maryland 21204

**State Registrar**

31. Date filed (Month Day Year): FEB 20 2001
32. Registrar's Signature: Penny G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04775

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| SHARON D. ANDERSON | FEB 16 2001 | 4:30 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3309 Leighton Avenue | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-86-6288 | 1☐ M 2☒ F | 31 Yrs. | | | 10/31/1969 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 3309 Leighton Avenue | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - Americen Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Detes: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10 | | Domestic Worker | Housekeeper |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Anderson | Victoria (unknown) |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Tylanvis Lawson / Friend | 3309 Leighton Ave., Baltimore, Maryland 21215 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Name of cemetery, crematory or other piece) | Dete | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify) | Mt. Zion Cemetery | 02/22/2001 | Landsdowne, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Derrick C. | Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent Cavitary Pneumonia

Due to (or as e consequence of):

b. AIDS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnency 4☐ Pregnent at time of deeth 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probebly 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

| 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|
| | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Dete signed (Month, Dey, Year) |
|---|---|---|
| ▶ Andrew R. Mayer, MD | D 30977 | 2/19/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew R. Mayer, MD 2435 W. Belvedere Ave Baltimore, Maryland 21215

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**To be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04776

Bohannan, Ida

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Dey / Yaer | 3. Time of Death |
|---|---|---|
| Ida Mae Bohannan | February 17 2001 | 11:35AM |

| 4a. Facility Nama (If not institution, give street and number) | 4b. City, Town, or Location of Deeth | 4c. County of Deeth |
|---|---|---|
| Franklin Square Hospital Center | Rosedale | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthdey) | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min. | 8. Dete of Birth (Month, Dey, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-05-0382 | 1☐ M 2☒ F | 92 Yrs. | | | Dec. 18, 1908 | Maryland |

Usuel Residence of Decedent

| 10a. Stete | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Parkville | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 8810 Walther Blvd. #3515 Trevor | 21234 | United States |

| 11. Maritel Status | 12. Wes Decedent Ever in U.S. Armed Forces? | 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) | 14. Race - Americen Indien, Black, White, etc. |
|---|---|---|---|
| 1☐ Nevar Married 2☐ Merried 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Yeer or Detes: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grede completed) | | 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondery (0-12) | College (1-4or 5+) | | |
| 12th Grade | | Sales | Photography Business |

| 17. Fathar's Neme (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumame) |
|---|---|
| Samuel David Anderson | Goldie J. Schaeffer |

| 19a. Informent's Neme/Reletionship (Type, Print) | 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Evelyn Buckless - Sister | 4246 Darleigh Road; Perry Hall, MD 21236 |

| 20a. Method of Disposition | 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify) | Lorraine Park Cemetery | 2/21/01 | Woodlawn, Maryland |

21. Signature of Funeral Service Licensee: ▶ [signature] 10088

22. Name and Addrass of Facility: Loring Byers Funeral Directors Inc. 8728 Liberty Road; Randallstown, MD 21133

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or compticetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

| | | Approximete Intervet Between Onset end Death |
|---|---|---|
| Immediate Ceuse (Final disaasa or condition resulting in deeth) | e. Pneumonia | 15 days |
| | Due to (or es e consequence of): | |
| Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last | b. | |
| | Due to (or es e consequence of): | |
| | c. | |
| | Dua to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Wes en eutopsy performed? | 24b. Were eutopsy findings aveilable prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Wes cese referred to medical examinar? | 26. Piece of Deeth (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify) |

| 27. Menner of Deeth | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Dascribe how Injury occurred |
|---|---|---|---|---|
| 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be datarmined | | M | 1☐ Yes 2☐ No | |
| | 28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) |

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

| 29b. Signeture end title of certifier | 29c. Licensa number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | RD 203349 | February 17, 2001 |

30. Neme and eddrass of person who completed cause of daath (Item 23a) (Type, Print): Dr. Virganeyce Lyons 9000 Franklin Square Drive Baltimore, MD 21237

**State Registrar**

| 31. Dete filed (Month, Dey, Year) | 32. Registrar's Signatura |
|---|---|
| FEB 2 0 2001 | ▶ Geneva G Sparks |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Evelyn Buckless - Sister

X

Lorraine Park Cemetery 2/21/01 Woo

Loring Byers Funeral Director
8728 Liberty Road; Randallst

RJD
DAVID M. BAASKE
01-942-025

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 04777

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| David Michael Baaske | FEBUARY 18, 2001 | 1453P. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| UPPER CHESAPEAKE MEDICAL CNTR | BELAIR | HARFORD |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 397-44-2530 | 1☒M 2☐F | 54 Yrs. | | | Feb 15, 1947 | WI |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Joppa | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2605 Old Joppa Road | 21085 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | Senior Director | Analytical Research & Development |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| David Baaske | Joan Heath |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Nancy Baaske /Wife | 2605 Old Joppa Road, Joppa, MD 21085 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from Stete 4☐Donation 5☐Other (Specify) | Chesapeake Crematory | Feb 23 2001 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] MO0986 | Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medicat examiner? 1☒Yes 2☐No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

| 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred |
|---|---|---|---|
| | | | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Stephen S. Radentz, M.D | O.C.M.E. | FEBUARY 19, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year) FEB 20 2001

32. Registrar's Signature ▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04778

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Clarence George Beck
2. Date of Death (Month, Day, Year): February 17, 2001
3. Time of Death: 10:40 AM
4a. Facility Name *(If not institution, give street and number)*: Genesis Elder Care
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-24-2401
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sep 17, 1927
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3 Hazel Drive
10f. Zip Code: 21220
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 3 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Trucking

17. Father's Name *(First, Middle, Last)*: Clarence Alonzo Beck
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Elizabeth Warfield

19a. Informant's Name/Relationship *(Type, Print)*: Linda Dostal /Friend
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3 Hazel Drive, Baltimore, MD 21220

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory — Date: Feb 19 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Laura C. Hardesty
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia
Due to (or as a consequence of):
b. Decubitus ulcer
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Sepsis
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rachelle Gajadhar, MD
29c. License number: D0056705
29d. Data signed *(Month, Day, Year)*: 02/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RACHELLE GAJADHAR, 3007 E. NORTHERN PKWY, BALTIMORE MD 21214

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 2 0 2001
32. Registrar's Signature: Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04779

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Joseph H. Blackwell
2. Date of Death: Month FEB Day 15 Year 2001
3. Time of Death: 11:58 AM
4a. Facility Name (If not institution, give street and number): ST AGNES HEALTHCARE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 220-05-3236
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 20, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 841 N. Bentalou St.
10f. Zip Code: 21216
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: National Institute Health

17. Father's Name (First, Middle, Last): Harvey Blackwell
18. Mother's Name (First, Middle, Maiden Surname): Sarah Watts

19a. Informant's Name/Relationship (Type, Print): (sister) Mrs. Clarice McClain
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 841 N. Bentalou St. Balto. Md. 21216

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore National | Date: 2/21/2001
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. END STAGE RENAL DISEASE 2° DIABETES — 1 WEEK

Due to (or as a consequence of):
b. HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Appea MD
29c. License number: 14445
29d. Date signed (Month, Day, Year): FEB, 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LOUISA APPEA-DANQUAH, ST AGNES HOSPITAL, 900 CATON AVE, BALTIMORE MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: Steven G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

NAME JOSEPH BLACKWELL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND#18 PER F.H. G792 2-20-2001 JAB

# Certificate of Death

Reg. No. 2001 04780

PATIENT KNOWN AS COLLIS M. BLOW

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): COLLIS MASO BLOW
2. Date of Death: Month FEBRUARY Day 16 Year 2001
3. Time of Death: 18:42
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 218-42-3081
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 14, 1944
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5007 SUNSET ROAD
10f. Zip Code: 21215
10g. Citizen of What Country? USA.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12) / College (1-4or 5+): 2 YRS.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): POLICE OFFICER
16b. Kind of Business/Industry: BALTO. CITY POLICE DEPT.

17. Father's Name (First, Middle, Last): MILTON ARCHIE BLOW
18. Mother's Name (First, Middle, Maiden Surname): ~~THERESA~~ THERESA MONK

19a. Informant's Name/Relationship (Type, Print): CASSANDRA BLOW (WIFE)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 5007 SUNSET ROAD, BALTIMORE, MD. 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY
Date: 02-24-01
20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO. MD. 21217

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiretory erest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in death): a. SEPSIS — 24 HOURS

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Lest

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco uaa contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: [signature], M.D., PGY-1
29c. License number: RESØØØ
29d. Date signed (Month, Day, Year): FEBRUARY 16, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): DAVID C. LOTT, M.D.
SINAI HOSPITAL, 2401 WEST BELVEDERE AVENUE, BALTIMORE, MARYLAND 21215

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

Amend Item 1,G793,per Phy.,03/08/01dhb

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04781

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ~~BISHOP~~ WILLIE ROYAL BURGESS SR.
2. Date of Death Month: February Day: 16 Year: 2001
3. Time of Death: 0640 AM
4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 251-54-1377
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEPT. 10, 1933
9. Birthplace *(State or Foreign Country)*: SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 3801 GARRISON BLVD
10f. Zip Code: 21215
10g. Citizen of What Country?: USA.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 6+11 GRADE — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: PASTOR
16b. Kind of Business/Industry: CHURCH
17. Father's Name *(First, Middle, Last)*: LEROY BURGESS
18. Mother's Name *(First, Middle, Maiden Surname)*: ELLA LEE HOLIDAY
19a. Informant's Name/Relationship *(Type, Print)*: SUSIE BURGESS (WIFE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3801 GARRISON BLVD, BALTIMORE MD. 21215
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: KING MEMORIAL PARK — Date: 02-24-01
20c. Location - City or Town, State: WOODLAWN, MARYLAND
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTO. MD. 21217

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not antar tha moda of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in death)
a. Massive myocardial infarction — 30 minutes
Due to (or es a consequence of):
Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in death) Last
b. Coronary artery disease — 10 years
Due to (or as e consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: acute on chronic renal failure; dilated cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No
24b. Were eutopsy findings availeble prior to completion of ceuse of death? 1☐Yas 2☒No

25. Was cese referred to medical examiner? 1☐Yes 2☑No
26. Ptece of Deeth *(Check only one)*: Hospitel: 1☑Inpatient 2☐ER/Outpetient 3☐DOA — Othar: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*
27. Menner of Deeth: 1☑Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Panding invastigetion 6☐Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ Baumta MD
29c. License number: RES 000
29d. Date signed *(Month, Dey, Year)*: February 16, 2001

30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): B. Acosta MD, Sinai Hospital of Baltimore, Baltimore Maryland

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 2 0 2001
32. Registrar's Signature: ▶ [signature]

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

Patient known as Willie R. Burgess

5

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04782

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Robert F. Baytops

2. Date of Death (Month, Day, Year): FEBRUARY 16 2001

3. Time of Death: 19:33

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-38-8418

6. Sex: 1 ☑ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 57 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 2, 1943

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☑ Yes 2 ☐ No

10e. Street and Number: 103 Allendale

10f. Zip Code: 21229

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Correctional Officer

16b. Kind of Business/Industry: Prison

17. Father's Name *(First, Middle, Last)*: Alvin F. Baytops

18. Mother's Name *(First, Middle, Maiden Surname)*: Mercilease Jones

19a. Informant's Name/Relationship *(Type, Print)*: Mercilease Baytops-mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 103 Allendale Balto., MD. 21229

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest V.A. Cemetery — Date: 2-22-01

20c. Location - City or Town, State: Owings Mills, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Gary L. March Funeral Home Inc. 2710 Frederick Rd Balto., MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. ACUTE MYOCARDIAL INFRACTION

Due to (or as a consequence of):
b. SEVERE HYPO GLYCEMIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. DIABETES

Due to (or as a consequence of):
d. CORONARY ARTERY DISEASE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D5001865

29d. Date signed *(Month, Day, Year)*: FEBRUARY 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES CURTIS BALTIMORE, MD ST AGNES HOSPITAL

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baytops Robert

6 of 1

Curtis Backmon
crn
01-0916-510

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23,ptII,&27 per ME G792 050101 SS

# Certificate of Death

Reg. No. 2001 04783

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Curtis Backmon
2. Date of Death Month Day Year: February 17, 2001
3. Time of Death: 4:30 AM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Locetion of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-84-1717
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 36 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): 11-03 1964
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street end Number: 4710 Greenhill Ave.
10f. Zip Code: 21206
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UKW.
16b. Kind of Business/Industry: Self Empolyment

17. Father's Name (First, Middle, Last): Curtis Lee Backmon
18. Mother's Name (First, Middle, Meiden Surname): Deloris Suggs

19a. Informant's Name/Relationship (Type, Print): Alesia Backmon - wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 4710 Greenhill Ave. Baltimore, maryland 21206

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): mt. Zion cemetery Date: 2/23/2001
20c. Location - City or Town, State: Baltimore, maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: miller's Metropolitan Chapel 1639 N. Broadway 21213

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. list only one ceuse on each line. — Approximate Intervat Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death):
a. DILATED CARDIOMYOPATHY
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the pest 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
CHRONIC RENAL FAILURE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was en autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Theodore M. King MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 17, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Yeer): FEB 20 2001
32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 17 Rev 1/2001

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

OK on Pendrill

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04784

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CLINTON L. BARLOW III
2. Deta of Deeth: Month FEB. Day 13, Yaer 2001
3. Time of Death: 6:30PM
4a. Facility Name (If not institution, give street end number): 715 S. MONTFORD AVE.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-07-4909
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): 5/23/17
9. Birthpiece (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usuei Rasidence of Decedant

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 715 S. MONTFORD AVE.
10f. Zip Code: 21224
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- if Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indien, Bieck, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupetion (Give kind of work done duning most of working life. DO NOT use retired): WIRE MILL
16b. Kind of Business/Industry: BETH STEEL
17. Father's Neme (First, Middle, Last): CLINTON L. BARLOW JR.
18. Mother's Name (First, Middle, Maiden Surneme): ELEANOR HORSEMAN
19a. Informent's Neme/Reietionship (Type, Print): MRS. EVELYN BARLOW
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 715 S. MONTFORD AVE. BALTO., MD. 21224
20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): PARKWOOD CEME. Date: 2/17/01
20c. Location - City or Town, State: BALTO., MD.
21. Signatura of Funaral Servica Licensee: Eugene J. Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 2525 FLEET ST. BALTO., MD. 21224

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or Heart feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in deeth):
a. METASTATIC LIVER DISEASE — 12 MONTHS
Due to (or es e consequenca of):
b. COLON CANCER — 18 MONTHS

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last
Due to (or es a consequence of):
c.
Dua to (or es e consequence of):
d.

Part II. **Other eignificant conditions** contributing to death but nof resulting in tha underlying cause given in Part I.
MALNUTRITION
UREMIA
ANEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)
27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner**: On tha basis of exeminetion and/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) and menner steted.
29b. Signature and title of certifier: D36974
29c. License number: D 36974
29d. Date signed (Month, Dey, Year): FEB 15, 2001
30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): DAVID O. NYANJOM MD 301 ST. PAUL PLACE # 607 BALTIMORE MD 21202

**State Registrar**

31. Dete filed (Month, Dey, Year): FEB 20 2001
32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04785

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): SARAH MARGARET BRAUN
2. Date of Death (Month, Day, Year): FEBRUARY 14, 2001
3. Time of Death: 5:30 PM
4a. Facility Name (If not institution, give street and number): St. Elizabeth Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 216-07-4980
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03/13/1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3320 Benson Avenue
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronics Assembler
16b. Kind of Business/Industry: Westinghouse
17. Father's Name (First, Middle, Last): Frank LaMartina
18. Mother's Name (First, Middle, Maiden Surname): Mary Giglio
19a. Informant's Name/Relationship (Type, Print): Carol Haines-niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 752 220th Street, Pasedena, Maryland, 21122
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): New Cathedral Cemetery
Date: 02/17/01
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Wanda L Lemmer
22. Name and Address of Facility: Witzke Funeral Home Of Catonsville 1630 Edmondson Avenue, Catonsville,MD., 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ACUTE MYOCARDIAL INFARCTION — 5 MINUTES

Due to (or as a consequence of):
b. CORONARY HEART DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Lung Disease
Alzheimer's disease

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATTENDING PHYSICIAN
29c. License number: D16200
29d. Date signed (Month, Day, Year): FEBRUARY 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NORBERTO M. MACHIRAN, MD. 720-C MAIDEN CHOICE LA. BALTO. MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: for G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04786

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

## To Be Completed by Funeral Director

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Richard Gordon Ball
2. Date of Death: Month: February Day: 15 Year: 2001
3. Time of Death: 13:25
4a. Facility Name (If not institution, give street and number): 1420 N. Rolling Road
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-18-9334
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/27/1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1420 N. Rolling Road
10f. Zip Code: 21228
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943 1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Telephone Installer
16b. Kind of Business/Industry: Bell Atlantic

17. Father's Name (First, Middle, Last): Edgar Ball
18. Mother's Name (First, Middle, Maiden Surname): Annie Airey

19a. Informant's Name/Relationship (Type, Print): Ruth Ball-wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1420 N. Rolling Road, Catonsville, MD., 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olive Cemetery
Date: 02/19/01
20c. Location - City or Town, State: Randallstown Md.

21. Signature of Funeral Service Licensee: Wanda L Lemmer M00741
22. Name and Address of Facility: Witzke Funeral Of Catonsville, 1630 Edmondson Avenue, Catonsville, MD., 21228

## Medical Certification: To Be Completed by Physician/Medical Examiner

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Parkinson's Disease — 4 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Date of Injury (Month, Day Year)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patrick W. White M.D.
29c. License number: D23365
29d. Date signed (Month, Day, Year): 2/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patrick W. White, 716 Marden Chateau #205, Baltimore, MD

## State Registrar

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04787

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Beverly LeRoy Bray, Jr.
2. Date of Death: Month 02 Day 16 Year 2001
3. Time of Death: 4:10 PM
4a. Facility Name (If not institution, give street and number): 12233 Etchison Road
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 220-42-9201
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-24-1944
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 12233 Etchison Road
10f. Zip Code: 21042
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 1 Year
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrical Contractor
16b. Kind of Business/Industry: Bray Electric Co.

17. Father's Name (First, Middle, Last): Beverly LeRoy Bray
18. Mother's Name (First, Middle, Maiden Surname): Ethel Tiddings

19a. Informant's Name/Relationship (Type, Print): Susan Bray - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12233 Etchison Rd., Ellicott City, MD. 21042

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Cemetery
Date: 02-20-2001
20c. Location - City or Town, State: Ellicott City, MD.

21. Signature of Funeral Service Licensee: Bernard Balmer
22. Name and Address of Facility: Witzke Funeral Home of Catonsvill, 1630 Edmondson AVe., Balt., MD. 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Colonic Adenocarcinoma stage IV — 22 months.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Anemia, Anorexia-Cachexia; Liver-Failure 2° to; Mets

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jon K. Minfeld MD
29c. License number: D30543
29d. Date signed (Month, Day, Year): 2-20-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jon K. Minfeld, MD 11065 Little Patuxent Parkway Columbia MD 21044

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Bernard G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04788

**Physician /Medical Examiner**

1. Decedent's Neme *(First, Middle, Last)*: June Burlin

2. Date of Death Month: 2 Day: 13 Year: 01

3. Time of Death: 8:10 pm

4a. Facility Neme *(If not institution, give street end number)*: Mariner Health of Catonsville

4b. City, Town, or Location of Deeth: Catonsville

4c. County of Deeth: Baltimore

**Funeral Director**

5. Social Security Number: 213-28-4174

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthdey)*: 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Yeer)*: June 27, 1930

9. Birthplace *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 537 Parksley Avenue

10f. Zip Code: 21223

10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machine Operator

16b. Kind of Business/Industry: Spice Factory

17. Feiher's Name *(First, Middle, Last)*: Thomas Beutelspacher

18. Mother's Name *(First, Middle, Maiden Surneme)*: Mary Gloag

19e. Informent's Neme/Relationship *(Type, Pnht)*: Edwin T. Burlin - son

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1222 Weddel Avenue, Baltimore, Maryland 21227

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Loudon Park Cemetery

Dete: 2/17/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: Ann Y. Zink

22. Neme end Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediete Cause (Final diseese or condition resulting in deeth) e. | Ischemic bowel | 7d |
| Due to (or es a consequence of): b. | Sepsis | 7d |
| Sequentially list conditions, if any, leading to Immediete ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest: Due to (or as a consequence of): c. | peripheral vascular disease | 1yr |
| d. | | |

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) end manner steted.

29b. Signeture and title of certifier: physician

29c. License number: D29769

29d. Date signed *(Month, Dey, Yeer)*: 2/15/01

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Marcelino D. Alaverna MD 516 N. Rolling Rd Baltimore MD 21228

**State Registrar**

31. Dete filed *(Month, Dey, Yeer)*: FEB 20 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04789

Bright, Sue Mackey

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: SUE CALDWELL MACKEY BRIGHT
2. Data of Death Month Day Year: FEBRUARY 17, 2001
3. Time of Death: 10:37 PM
4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 185-28-1976
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 9, 1936
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 806 West Lake Avenue
10f. Zip Code: 21210
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nuclear Medicine Technician
16b. Kind of Business/Industry: Medicine

17. Father's Name *(First, Middle, Last)*: Paul George Mackey
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Sidnie Baird Gilbert

19a. Informant's Name/Relationship *(Type, Print)*: John E. Bright (Husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 806 West Lake Avenue, Baltimore, Maryland 21210

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Green Mount Crematory
Date: 2/20/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SEPSIS | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. ACUTE CHOLECYSTITIS | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ISCHEMIC BOWEL

ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D30263
29d. Date signed *(Month, Day, Year)*: 2-18-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS KHOO, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001
32. Registrar's Signature: D. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

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DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04790

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARGARET BURGESEN
2. Date of Death Month: FEBRUARY Day: 20TH Yaar: 2001
3. Time of Death: 3:25 AM
4a. Facility Name (If not institution, giva street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 217-16-3780
6. Sax: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Jan 25, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Owings Mills
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2218 Caves Road
10f. Zip Code: 21117
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grade completed)
Elementary/Secondary (0-12): 10
College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Joseph Shay
18. Mother's Name (First, Middle, Maiden Sumeme): Katherine Allen

19e. Informant's Name/Reletionship (Type, Print): Jacob M.S. Burgesen
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2218 Caves Road Owings Mills, Maryland 21117

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Carroll Cremation Serv.
Date: 02/21
20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funaral Service Licensea: Stephen M Jenkins
22. Name and Address of Fecility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in deeth): a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.: CONGESTIVE CARDIOMYOPATHY.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Placa of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. Licansa number: D 42723.
29d. Date signed (Month, Dey, Year): FEBRUARY 20TH 2001

30. Nama end address of person who completed cause of death (Item 23e) (Type, Print): AVVERAHALLI M HARISH. RANDALLSTOWN 5401 OLD COVAT ROAD MD 21133.

**State Registrar**

31. Date filed (Month, Dey, Year): FEB 20 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 04791

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| CYRIL BECK | FEBRUARY 18 2001 | 9:10 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| GOOD SAMARITAN HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-03-4110 | 1☒ M 2☐ F | 88 Yrs. | | | Sept. 24, 1912 | Md. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Baltimore | Baltimore | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8810 Walther Blvd. #1602 | 21234 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | 4 | Manager | Martins |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Harry T. Beck | Rissa Hill |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Craig T. Beck/son | 13370 S. W. Peters Rd. Lake Oswego, Or. 97035 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Hilltop Service Corp. | 2/20/01 | Towson, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| | Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE

Due to (or as a consequence of):
b. SEVERE PULMONARY FIBROSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD. | P13457 | FEBRUARY 18 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROSEMARIE MARAS c/o GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD BALTIMORE MD 21239

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | |

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04792

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MARY G. BENDA

2. Date of Death (Month, Day, Year): FEBRUARY 18, 2001

3. Time of Death: 10:50PM

4a. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 295-50-0632

6. Sex: 1☐ M XX F

7. Age *(In yrs. last birthday)*: 49 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: 05-08-1951

9. Birthplace *(State or Foreign Country)*: W.VIRGINIA

Usual Residence of Decedent

10a. Stete: TN.

10b. County: N/A

10c. City, Town or Location: OOLTEWAH

10d. Inside City Limits: XX 1 Yes 2☐ No

10e. Street and Number: 9231 LOCH HAVEN COVE

10f. Zip Code: 37363

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married XX Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U,S. Armed Forces? 1☐ Yes XX No If Yes, Give Yaar or Detas:

13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes XX No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 5 PLUS

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SPEECH PATHOLOGIST

16b. Kind of Business/Industry: EDUCATION

17. Father's Name *(First, Middle, Last)*: GOODLOE J. DADISMAN

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY J. HUMPHREYS

19a. Informant's Name/Relationship *(Type, Print)*: JOHN P. BENDA (HUSBAND)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 9231 LOCH HAVEN COVE,OOLTEWAH,TN.,37363

20a. Method of Disposition: 1☐ Burial XX Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: GREEN MOUNT CREMATORY

Date: 2-19

20c. Location - City or Town, State: BALTIMORE,MD.,21202

21. Signature of Funerel Service Licensee: ▶ R. J. Butler

22. Name end Address of Facility: HENRY W. JENKINS AND SONS COMPANY 6500 YORK ROAD,BALTIMORE,MARYLAND,21212

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. SEPSIS — TWO DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last

b. LEUKEMIA — EIGHT MONTH

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uaa contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably XX Unknown

24a. Was an autopsy performed? 1☐ Yes XX No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes XX No

26. Place of Death *(Check only one)*: Hospital: XX 1 Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: XX 1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: XX 1 **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: FEBRUARY 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MIKE GIBSON, M.D.,JOHNS HOPKINS HOSPITAL, BALTIMORE,MARYLAND,21205

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04793

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Marian Michelle Brennan

2. Data of Death Month Day Year: FEBRUARY 14, 2001

3. Time of Death: 08:10 AM

4a Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 195-30-6400

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: April 26, 1939

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 3029 Pinewood Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrative Assistant

16b. Kind of Business/Industry: Loyola College

17. Father's Name *(First, Middle, Last)*: Robert John Brennan

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Ann Gaughan

19a. Informant's Name/Relationship *(Type, Print)*: Brennan Prodey/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2202 Lake Avenue Baltimore MD 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Moreland Memorial Park

Date: 2/19/01

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Christina L. Hilton

Christina L. Hilton

22. Name and Address of Facility: Leonard J. Ruck, Inc.
5305 Harford Road
Baltimore, Maryland 21214

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER OF UNKNOWN PRIMARY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*

1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D30263

29d. Date signed *(Month, Day, Year)*: 2-14-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCIS, KHOO M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04794

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| ROSE B. BINDER | FEBRUARY 18 2001 | 11:50AM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| RUXTON OF PIKESVILLE | BALTIMORE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-10-7479 | 1☐ M 2☒ F | 78 Yrs. | | | JULY 19 1922 | MARYLAND |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7 SUDBROOK LANE | 21208 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | NONE | NONE |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| SIMON BINDER | SYLVIA KOVENS |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. BEE KONGSTED/SISTER | 5 POMONA NORTH APT.11 BALTIMORE,MD. 21208 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | LIBERTY PARK-SHAAREI ZION CONGREGATION | 2/19/2001 | RANDALLSTOWN,MD. |

21. Signature of Funeral Service Licensee: Jay Alan

22. Name and Address of Facility: SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE,MD.21208

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

| IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☑ Unknown | 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Tasneem Lakhani | D28595 | 2/19/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | Received G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

01-0890-005
crn
Joseph Bongiovano

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMENDED ITEM# 23a,b & 27 per ME G793 050701 ss

Reg. No. 2001 04795

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Joseph Anthony George Bongiovano
2. Date of Death Month Day Year: February 16, 2001
3. Time of Death: 8:15 AM
4a. Facility Name (If not institution, give street and number): 2032 Barry Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-62-9980
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 44 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 13,1956
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2032 Barry Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1979
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 Years
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waste Management
18b. Kind of Business/Industry: Onyx Corp.

17. Father's Name (First, Middle, Last): Charles Bongiovano
18. Mother's Name (First, Middle, Maiden Surname): Anna Russo

19a. Informant's Name/Relationship (Type, Print): Mr. Michael Bongiovano (Brother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6846 Dunbar Road Dundalk, Maryland 21222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Ht. of Jesus
Date: 2/20/2001
20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Duane C. Carroll
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARRHYTHMIA
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnent in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnency 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23e. Did tobecco use contribute to the ceuse of death? 1 [ ] Yes 2 [ ] No 3 [X] Probebly 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) at scene

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chutkow
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chutkow 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04796

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: HELEN COTTON
2. Data of Death Month / Day / Year: January 13, 2001
3. Time of Death: 10:35 am
4a. Facility Name *(If not institution, give street and number)*: Lorien Nursing Home
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 578-40-8720
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Oct. 23, 1912
9. Birthplace *(State or Foraign Country)*: Virginia

Usual Residence of Decedant

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 6336 Cedar Lane #344
10f. Zip Code: 21044
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elamentary/Secondary (0-12): 11th; Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Clerk
16b. Kind of Business/Industry: Telephone Company

17. Fathar's Nama *(First, Middla, Last)*: Charles Richard Railey
18. Mothar's Nama *(First, Middle, Maiden Sumama)*: Hattie E. Allen

19a. Informant's Name/Ralationship *(Type, Print)*: Helen Weisman/Daughter
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 3600 Mystic Pt. Drive, Adventure FL 33180

20a. Method ot Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place ot Disposition *(Nama of camatery, cramatory or othar place)*: Cedar Hill Cemetery
Data: 1-19-01
20c. Location - City or Town, Stata: Suitland, Maryland

21. Signature of Funaral Sarvice Licensee: Shawna L Braxton
22. Nama and Addrass ot Facility: MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746

**Physician /Medical Examiner**

23a. Part I. Enter the diseasa, or complications that caused the death. Do not anter tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart tailura. List only ona causa on aach lina.

Approximata Intarval Between Onset and Daath

Immediata Causa (Final disaasa or condition rasulting in daath)
a. Renal Failure — 6-8 weeks
Dua to (or as a consequanca ot):
b. Dehydration — 6-8 weeks
Dua to (or as a consequanca ot):
Sequantially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Disaase or Injury that initiated avants rasulting in daath) Last
c. Left hip fracture S/P ORIF — 2 weeks
Dua to (or as a consequance ot):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: dementia, osteoporosis, s/p pelvis fracture 12/99

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to complation of causa of death? 1☐ Yas 2☐ No

25. Was casa ratarrad to medical examinar? 1☒ Yas 2☐ No
26. Placa ot Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determinad
28a. Date of Injury *(Month, Day Year)*: Dec. 31, 2000
28b. Time of Injury: 16:15 M
28c. Injury at Work? 1☐ Yas 2☒ No
28d. Describe how injury occurrad: fell while ambulating
28a. Placa of Injury - At homa, farm, street, tactory, office building, atc. *(Specify)*: Home
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*: Lorien Nursing Fac. 6336 Cedar Lane, Columbia, MD

29a. Cartifiar *(Check only ona)*: 1☐ **Certifying Physician**: To tha best ot my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☒ **Medical Examiner**: On tha basis ot axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.
29b. Signature and title of cartifiar: Patryce A Toye MD Deputy ME
29c. Licansa number: D31473
29d. Data signed *(Month, Day, Year)*: Feb 12/01
30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): PATRYCE A TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 20 2001
32. Registrar's Signatura: Geneva B Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04797

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Antonino Cotroneo

2. Data of Death: Month Feb. Day 15 Yaar 2001

3. Tima of Death: 5:26 PM

4a Facility Nema (If not institution, giva street and number): Gilchrist

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-68-3698

6. Sex: 1 [X] M 2 [ ] F

7. Aga (In yrs. last birthday): 56 Yrs.

If Under 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): July 1 1944

9. Birthplace (State or Foraign Country): Italy

Usual Residance of Dacedant

10a. Stata: MD

10b. County: Baltimore

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 600 Straffan Dr., Unit 301

10f. Zip Code: 21093

10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No. If Yes, Giva Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - Amarican Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 2; Collega (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): Barber

16b. Kind of Business/Industry: Health & Beauty

17. Fathar's Name (First, Middla, Last): Pasquale Catroneo

18. Mothar's Nama (First, Middla, Maiden Sumama): Antonia Tramontana

19a. Informant's Neme/Ralationship (Type, Print): Antoinette Cotroneo/daughter

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 910 W. Seminary Ave., Lutherville, MD 21093

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cematery, crematory or other piece): Dulaney Valley Memorial Gardens

Data: 1/19/01

20c. Location - City or Town, Stata: Timonium, MD 21093

21. Signature of Funaral Service Licensee: Lowell M. Lemmon

22. Name end Addrass of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or respiratory errast, shock, or haart failura. List only ona causa on each lina.

Approximata Intarval Batwaan Onset and Deeth

Immediate Cause (Final disaasa or condition rasulting in death): a. rhabdomyosarcoma — months

Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaase or injury that initiated evants rasulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Ware autopsy findings available prior to completion of causa of daath? 1 [ ] Yas 2 [ ] No

25. Wss case rafarrad to medical axaminar? 1 [ ] Yas 2 [X] No

26. Placa of Death (Check only ona)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Homa 5 [ ] Residanca 6 [X] Othar (Specify) Hospice

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending Invastigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Cartifiar (Check only one): 1 [X] **Certifying Physician**: To tha best of my knowledge, deeth occurred at tha time, date end place, and dua to tha cause(s) and mennar as stated. 2 [ ] **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and mannar steted.

29b. Signature end title of certifiar

29c. License number: D0051926

29d. Data signed (Month, Day, Year): Feb 16, 2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Helen M Gordon MD 6565 N. Charles St, Baltimore MD 21204

**State Registrar**

31. Data filed (Month, Day, Year): FEB 2 0 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

Cotroneo, Antonio 2/15/01

5:26 pm

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04798

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Alice E. Fisher Coleman
2. Date of Death — Month: 02 Day: 16 Year: 2001
3. Time of Death: 6:40 P.M.
4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-44-0901
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 08-05-1944
9. Birthplace *(State or Foreign Country)*: Sparks MD.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1 Brett Court #114
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest greda completed)*: Elementery/Secondary (0-12): 12 th — College (1-4or 5+): 2 yrs.
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Screener
16b. Kind of Business/Industry: State Of Maryland

17. Fether's Neme *(First, Middle, Last)*: Alphonso Fisher Sr.
18. Mother's Name *(First, Middle, Maiden Surneme)*: Alberta Madden

19a. Informent's Name/Reletionship *(Type, Print)*: Dina Coleman - Reed (Daughter)
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 9404 Windpine Rd. Balto., Md. 21220

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Placa of Disposition *(Neme of cemetary, crematory or othar place)*: King Memorial Park
Dete: 2-23-01
20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: Dennis B Caple
22. Neme end Address of Fecility: Dennis B. Caple Funeral Home P.A. 4601 York Rd. Balto., Md. 21212

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert teilure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immedlete Ceuse (Final diseese or condition resulting in deeth)
e. ACQUIRED IMMUNE DEFICIENCY SYNDROME
Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immedlete cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Invastigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Streat end Number or Rurel Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner steted.

29b. Signature and title of certifier
29c. Licansa number: D43725
29d. Date signed *(Month, Dey, Year)*: 2/19/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 20 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

FEBUARY 16, 2001 6:40 p.m.

Division of Vital Records, P.O. Box 68760,

ALICE FISHER

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Michael Anthony Cook, III
crn
01-0682-025

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM 23,27 per ME G793 032101 SS

# Certificate of Death

Reg. No. 2001 04799

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Michael Anthony Cook III | February 07, 2001 | 9:03 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Upper Chesapeake Medical Center | Bel Air | Harford |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Dete of Birth (Month, Dey, Yeer) | 9. Birthplece (State or Foreign Country) |
|---|---|---|---|---|---|---|
| | 1☒ M 2☐ F | Yrs. | | 7 | Jan.31 2001 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Joppa | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 1012 Hanson Road | 21085 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Bleck, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | Cottege (1-4or 5+) | | |
| n/a | | n/a | n/a |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Neme (First, Middle, Meiden Sumeme) |
|---|---|
| Michael A. Cook Jr. | Victoria Ann Merritt |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Mary Sharff /grandmother | 1012 Hanson Road Joppa MD 21085 |

| 20a. Method of Disposition | 20b. Place of Disposition (Neme of cemetery, cremetory or other place) | Dete | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removet from State 4☐ Donation 5☐ Other (Specify) | Gardens of FAith 2/10/2001 | | Rossville MD |

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 MAce AVe. Baltimore MD 21221

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SUDDEN INFANT DEATH SYNDROME

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as e consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

| 24e. Was en autopsy performed? | 24b. Were eutopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☐ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medicat examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Yeer) |
|---|---|---|
| Dennis J Chutkow | O.C.M.E. | February 08, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chutkow 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | Geneva G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-1835-510 Amend Items#10e-f,18,19a perGENEVA Sparks G794 4/20/2001 EW

LASHAWN CHISHOLM

ASP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM 1 per ME G794 042501 SS AMENDED# 23& 27 per ME G793 031201 SS

# Certificate of Death

Reg. No: 2001 04800

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Lashawn Daveona Chisholm Woodrum | FEBRUARY 14 2001 | 0649 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| JOHNS HOPKINS HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Months | If Under 1 Year Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| N/A | 1 M X 2 F | Yrs. | 1 | 20 | | | Dec 25, 2000 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | N/A | Baltimore | X 1 Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| ~~3902 Erdman Avenue~~ 4509 Schley Ave | ~~21213~~ 21206 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| X 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes X 2 No If Yes, Give Year or Dates: | 1 Yes X 2 No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 0 | | N/A | N/A |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumeme) |
|---|---|
| James Owens | ~~Latarsha Chisholm~~ Sharron Woodrum |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Latarsha Chisholm ~~Mother~~ Care Taker | 3902 Erdman Avenue, Baltimore, MD 21213 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Voshell Memorial Park | Feb 19 2001 | Baltimore, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Calvin L. Williams | Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. SUDDEN INFANT DEATH SYNDROME | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnency 4 Pregnant at time of death 5 Other (specify) 9 Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 X Yes 2 No | 1 X Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatient 3 X DOA | Other: 4 Nursing Home 5 Residence 8 Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | M | 1 Yes 2 No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rurel Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, end due to the cause(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Yeer) |
|---|---|---|
| Joseph Pestaner M.D. | O.C.M.E | FEBRUARY 15, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | Geneva G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04801

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Beatrice Carroll
2. Data of Death Month Dey Yaer: February 17,2001
3. Tima of Death: 2:22a M
4a. Facility Nama (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Daath: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-05-3998
6. Sex: 1☐M 2☒F
7. Aga (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 10/11/1918
9. Birthplace (State or Foraign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐Yas 2☒No
10e. Street and Number: 22 Dunvale RD Apt. A.T.
10f. Zip Coda: 21204
10g. Citizan of Whal Country?: USA
11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐Yas 2☒No If Yes, Giva Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Ricen, atc.) 1☐Yas 2☒No Specify:
14. Raca - Amaricen Indian, Black, Whita, atc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 / Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Calibrator - Assembler
16b. Kind of Businass/Industry: Bendex
17. Father's Nama (First, Middle, Last): Royal Jackaway
18. Mother's Nama (First, Middle, Meiden Sumame): Magdelan Braun
19a. Informant's Name/Ralationship (Type, Print): Richard Carroll Son
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 4144 Hanover Pike, Westminster, MD 21102
20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or othar place): Balto-Wash. Crematory
Data: 02/20/01
20c. Location - City or Town, Stata: Laurel, Maryland
21. Signatura of Funeral Service Licensee: Robert Podack
22. Nama and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the daath. Do not anter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failura. List only one cause on eech lina.

Approximata Intarval Batwaan Onsat and Daath

Immediata Cause (Final disease or condition resulting in death): a. ACUTE ANTERIOR MYOCARDIAL INFARCTION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last:
b. Dua to (or as a consequence of):
c. Dua to (or as a consequance of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yas 2☒No 9☐Unknown
23c. If yes, outcoma of pregnancy 1☐Live birth 2☐Fetal daath 3☐Ectopic pregnancy 4☐Pregnant at tima of death 5☐Othar (specify) 9☐Unknown
23d. Date of dalivary Month Day Year

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.

23a. Did tobacco use contributa to tha ceusa of daath? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Wara autopsy findings available prior to complation of causa of daath? 1☐Yes 2☐No

25. Was cese refarred to medical examiner? 1☐Yes 2☒No

26. Placa of Death (Chack only ona)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Othar: 4☐Nursing Homa 5☐Rasidanca 6☐Othar (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be datarmined

28a. Date of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, streat, fectory, office building, atc. (Specify)
28f. Location (Straat and Numbar or Rural Routa Numbar, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowiedga, death occurrad at tha tima, data end place, and due to tha causa(s) and manner as statad. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, date end pleca, end dua to the causa(s) end mannar stated.

29b. Signatura and title of certifier: G. Robert Medalie MD
29c. Licensa number: D21398
29d. Date signed (Month, Day, Yaar): 2-17-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G. ROBERT MEDALIE 6565 N. CHARLES STE 305 BALTIMORE, MD 21204

**State Registrar**

31. Date filed (Month, Dey, Yaar): FEB 20 2001
32. Registrar's Signature: B. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Carroll Beatrice

DHMH 17 Rav 1/2001

ORIGINAL

01-0870-003
crn
Louis Frances Canneti, III

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar AMENDED# 23&27 per ME G793 031401 SS

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04802

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| LOUIS FRANCIS CANNETI III | February 14, 2001 | 9:55 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Anne Arundel Medical Center | Annapolis | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-02-3174 | 1☒M 2☐F | 26 Yrs. | | | 5/10/74 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | DUNDALK | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2418 MEADOW ROAD | 21222 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 0 | DIRECTIONAL BORING | RIGGS DISTLER |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| LOUIS FRANCIS CANNETI JR | KATHLEEN DUFFY |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MR.&MRS. LOUIS CANNETI | 2418 MEADOW RD. BALTO.,MD. 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | GARDENS OF FAITH | 2/17/01 | BALTIMORE, MD. |

21. Signature of Funeral Service Licensee: Charles Kaczorowski

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD 21222

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. HYPERTROPHIC CARDIOMYOPATHY | |
| Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as e consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of deeth 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) |
|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☒X **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J. Laron Locke M.D. | O.C.M.E. | February 15, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | per D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04803

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| Lawrence | E. | Carter | 02 / 10 / 2001 | 5:30 a M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Gardenview Nursing Home | Baltimore | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-20-9917 | 1 X M 2 ☐ F | 75 Yrs. | | | 06 25 25 | M.D. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | X Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 3502 Liberty Heights Ave | 21215 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | X Yes 2 ☐ No If Yes, Give Year or Dates: | 1 ☐ Yes X No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12th grade | 4yrs | Investigator | Federal Government |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Carter | Alice Owens |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Carolyn Carter-Wife | 3502 Liberty Height Ave, Baltimore Md 21215 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Loudon Park Cemetery | 2/19/01 | Baltimore, Md |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | March F/H West 4300 Wabash Ave, Baltimore 21215 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Atherosclerotic Cardiovascular disease | 10 Yr |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 ☑ No | 1 ☐ Yes 2 ☑ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 ☑ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] | 031865 | 2/12/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rm 206 821 N Gunter Street Baltimore md 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 2 0 2001 | ▶ [signature] |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

10

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04804

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: THURSTON CROUNSE

2. Date of Death Month: 2 Day: 17 Year: 01

3. Time of Death: 11:35 AM

4e. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS BAYVIEW

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: W/A

**Funeral Director**

5. Social Security Number: 215-22-9230

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 9, 1927

9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: DUNDALK

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7848 ST. Gregory Drive

10f. Zip Code: 21222

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: RECORDER- HOT STRIP

16b. Kind of Business/Industry: STEEL

17. Father's Name *(First, Middle, Last)*: Theodore Crounse

18. Mother's Name *(First, Middle, Maiden Surname)*: MYRTLE LESCHER

19a. Informant's Name/Relationship *(Type, Print)*: DOROTHY Crounse - wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7848 ST. Gregory Dr. BALTO. MD. 21222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GARDENS OF FAITH

Date: 2/20/01

20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: Anthony C. Connelly

22. Name and Address of Facility: Connelly Funeral Home of Dundalk, PA. 7110 Sollers PT. RD. BALTO. MD. 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Ischemic Cardiomyopathy — 20 years

Due to (or as a consequence of):

b. Coronary artery disease — 25 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Kidney Failure,

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Micol Roth, MD

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: FEBRUARY 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICOL ROTHMAN, MD JOHNS HOPKINS BAYVIEW HOSPITAL, MARYLAND

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No 2001 04805

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Elsie Ellen Cheek

2. Date of Death Month Day Year: February 16 2001

3. Time of Death: 1:10A M

4a. Facility Name (If not institution, give street and number): Future Care- Homewood

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 197-20-7020

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 2 1919

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1310 Putty Hill Ave.

10f. Zip Code: 21234

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Frederick Harris

18. Mother's Neme (First, Middle, Maiden Surneme): Olive Grimms

19a. Informant's Name/Relationship (Type, Print): Mrs. Sallie Stenger/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1360 Deanwood Rd. Baltimore, Md. 21234

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): Dulaney Valley Mem Gdn Dete: 2-19-01

20c. Location - City or Town, Stete: Timonium, Md.

21. Signature of Funeral Service Licensee: Kurt J. Fauss

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Possible Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes mellitis

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnent at time of deeth 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christopher M

29c. License number: D43564

29d. Date signed (Month, Day, Year): February 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3333 N. Calvert St., Ste 575, Baltimore, MD 21218

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: Jeanne D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04806

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Anna Gordon

2. Date of Death: Month 2 Day 10 Year 01

3. Time of Death: 11pm.

4a. Facility Name (If not institution, give street and number): Cocaisis Multi Medical Center

4b. City, Town, or Location of Death: Towson, Md.

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-09-6072

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7/26/09

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD | 10b. County: BALTIMORE | 10c. City, Town or Location: GLENMONT | 10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 6903 LACHLAN CIRCLE | 10f. Zip Code: 21239 | 10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th GRADE | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SELF EMPLOYED

16b. Kind of Business/Industry: CERAMIC STORE

17. Father's Name (First, Middle, Last): JOHN ONDERDONK

18. Mother's Name (First, Middle, Maiden Surname): ALEXANDRINA BARTON

19a. Informant's Name/Relationship (Type, Print): BARBARA ANN GORDON DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1525 CLEARWOOD ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MORELAND MEMORIAL PARK | Date: 2/17/01

20c. Location - City or Town, State: HILLENDALE, MD

21. Signature of Funeral Service Licensee: Heather N. Hayes

22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Carcinoma of Cervix | 1 year |
| Due to (or as a consequence of): b. | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SENile Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D17118

29d. Date signed (Month, Day, Year): Feb 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz MD 7700 York Rd 21204

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68768, Baltimore, Maryland 21215-0020**

ORIGINAL

01-0721-027
mnmr
Thomas Richard Conway
1- For State Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04807

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thomas R. Conway
2. Date of Death (Month, Day, Year): February 08, 2001
3. Time of Death: 1912 p M
4a. Facility Name (If not institution, give street and number): Brown's Motel 8074 Route 40 West
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 192-36-8069
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 54 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Janaury 24, 1947
9. Birthplace (State or Foreign Country): PA

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 ☐ Yes 2 XX No
10e. Street and Number: 8074 Baltimore National Pike
10f. Zip Code: 21043
10g. Citizen of What Country? United States

11. Maritat Status: 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No Unk. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Worker
16b. Kind of Business/Industry: Bill Collection

17. Father's Name (First, Middle, Last): Thomas R. Conway
18. Mother's Name (First, Middle, Maiden Surname): Marie T. Digiacomo

19a. Informant's Name/Relationship (Type, Print): Marie T. Conway / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1304 Rhawn Street, Apt 453 Philadelphia PA 19111

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 XX Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery Date: February 13, 2001
20c. Location - City or Town, State: Bensalem, PA

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive atherosclerotic cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

tF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 X Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) at scene

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 09, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Bernard B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04808

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Delbert Carr

2. Data of Death Month: 02 Day: 14 Year: 01

3. Time of Death: 4:45 AM

4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 233-44-3358

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: July 9, 1931

9. Birthplaca *(Stata or Foraign Country)*: Kentucky

Usual Rasidanca of Decedant

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Eastwood

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 7313 Stratton Way

10f. Zip Code: 21224

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yas, Giva Yaar or Datas: 1949-50

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - Amarican Indian, Black, Whita, etc. *Specify:* White

15. Decedant's Education *(Specify only highest grada compliated)*: Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT usa retired)*: Fireman

16b. Kind of Business/Industry: Baltimore City

17. Fathar's Nama *(First, Middla, Last)*: Albee Carr

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Sarah Sheila Baker

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Corine Carr (Wife)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 7313 Stratton Way Baltimore, Maryland 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: Oak Lawn Cemetery Data: 2/17/2001

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funaral Service Licensee: Grega E Rend

22. Nama and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the diseasa, or complications thet caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one ceuse on each lina.

Approximata Intarval Batween Onset and Deeth

Immediata Causa (Final diseasa or condition resulting in daath)

a. aspiration pneumonia — 4days

Dua to (or as a consaquanca of):

b. seizure — 5days

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Diseasa or injury that initiated events resulting in daath) Last

Due to (or as a consequence of):

c. cerebrovascular accident — 6weeks

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

hypertension, peripheral vascular disease

coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Were autopsy findings availabla prior to compliation of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, straat, factory, offica building, etc. *(Specify)*

28f. Location *(Straat and Numbar or Rural Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daeth occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: Michele F Bellantoni MD

29c. Licensa number: D33316

29d. Data signad *(Month, Day, Year)*: 02 14 01

30. Nama and address of person who compliated causa of daath (Item 23a) (Type, Print): Michele F Bellantoni MD 5505 Hopkins Bayview Circle Baltimore MD 21224

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04809

AMEND#19b PER F.H. G792 2-20-2001 JAB

FEBUARY 14, 2001 3:50 a.m.

Baltimore, Maryland 21215-0036

VIOLA CULOTTA

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner** | **Funeral Director** | **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Viola R. Culotta
2. Date of Death (Month, Day, Year): February 14, 2001
3. Time of Death: 3:50 AM
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore
5. Social Security Number: 217-09-8982
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 1,1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2300 Dulaney Valley Road
10f. Zip Code: 21093
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Drug Store
17. Father's Name (First, Middle, Last): John C. Wagner
18. Mother's Name (First, Middle, Maiden Surneme): Margaret Yeager
19a. Informant's Name/Relationship (Type, Print): Mrs. Earlene Kidd - Daughter
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 252 ~~Eat~~ EAST Falconry Ct. Hernando,FL 34442
20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): GArdens of Faith
Date: 2/17/01
20c. Location - City or Town, Stata: Baltimore,MD
21. Signature of Funeral Service Licensee: ▶ Paul L Hartenstine Jr
22. Name and Address of Facility: Baltimore,MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.

**Physician /Medical Examiner** | **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feiture. List only one ceuse on each line. Approximate Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in death): a. Bacteral Pneumonia

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last:
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☒ Other (Specify) HOSPICE
27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete and plece, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶
29c. License number: D43725
29d. Date signed (Month, Day, Year): 2/16/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: ▶ Barbara B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04810

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Leona Stella Crawford
2. Date of Death (Month, Day, Year): February 16, 2001
3. Time of Death: 8:25 AM
4a. Facility Name (If not institution, give street and number): Genesis Heritage Meridian Eldercare Ctr.
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-01-2800
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 19, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3011 Dunleer Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sorter
16b. Kind of Business/Industry: Nail Mill Manufacturing

17. Father's Name (First, Middle, Last): Charles Spiker
18. Mother's Name (First, Middle, Maiden Surname): Julia (Not Known)

19a. Informant's Name/Relationship (Type, Print): Mr. James Crawford, Jr. (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3011 Dunleer Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery — Date: 2/20/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: D. C. Caudell
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart faiture. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finat disease or condition resulting in deeth) a. | Acute Myocardial infarction | Seveal |
| Due to (or as a consequence of): b. | Ischemic Heart Disease | years |
| Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as e consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Chronic Anemia
Aspiration Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Illegible MD
29c. License number: D08358
29d. Date signed (Month, Day, Year): Feb 19 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GRACIA Y. PATRICIO 8903 HARFORD ROAD BALTIMORE MARYLAND

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04811

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: PERCY F. COOPER JR.

2. Date of Death Month Dey Year: FEB. 15, 2001

3. Time of Death: 1;45 PM

4e Facility Name *(If not institution, give street and number)*: MANOR CARE NURSING HOME

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-42-8191

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 56 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: feb. 12, 1945

9. Birthplece *(State or Foreign Country)*: MD.

Usuel Residence of Decedent

10a. Stete: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 526 E EAST AVENUE

10f. Zip Code: 21205

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Never Merried 2☐ Merried 3☐ Widowed 4☐ Divorced — X

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No — X
If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No — X Specify:

14. Race - American Indien, Bleck, White, etc.: AFRO-AMERICAN

15. Decedent's Education *(Specify only highest grade completed)* — X
Elementary/Secondery (0-12): GED
College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MAINTENACE TECHNICAN

16b. Kind of Business/Industry: ALLIANCE INC.

17. Fether's Neme *(First, Middle, Last)*: PERCY COOPER SR.

18. Mother's Neme *(First, Middle, Maiden Surname)*: BERNICE STAFFORD

19e. Informent's Neme/Reletionship *(Type, Print)*: WAYNE COOPER (BROTHER)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: #6 TENTMILL LANE BALTO. CO. 21208

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramoval from State 4☐ Donetion 5☐ Other *(Specify)* — X

20b. Pleca of Disposition *(Name of cemetery, crematory or other place)*: MT. ZION CEMETERY

Dete: FEB.22/01

20c. Location - City or Town, Stete: BALTO,MD.

21. Signefure of Funerel Service Licensee: [signature]

22. Neme end Address of Fecility: CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO,MD. 21213

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Bilatral cerebrovascular accident

Due to (or es e consequenca of):
b. Pneumia

Sequentially fist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
c. Hypertension

Due to (or es e consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
Anaemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Plece of Death *(Check only one)*
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steted.

29b. Signetura and title of certifier: [signature] MD

29c. License number: D 31464

29d. Date signed *(Month, Day, Year)*: 2/19/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): SHOAIB A. HASHMI 821 N. Eutaw St Suite 308 Balt MD 21201

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 20 2001

32. Registrer's Signeture: [signature] G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04812

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): George Ellisworth Devore
2. Date of Death Month Day Year: February 09, 2001
3. Time of Death: 0700
4a. Facility Name (If not institution, give street and number): 1006 Arncliffe Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 196-14-7959
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 27, 1924
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1006 Arncliffe Road
10f. Zip Code: 21221
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: U.S. Government
17. Father's Name (First, Middle, Last): Daniel Devore
18. Mother's Name (First, Middle, Maiden Surname): Dorthy Funk
19a. Informant's Name/Relationship (Type, Print): Clara Devore / Spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1006 Arncliffe Rd. Baltimore, MD 21221
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Foundation | Date: 02/9/01
20c. Location - City or Town, State: Laurel, Maryland
21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Anatomic Gift Foundation 13948 Baltimore Ave. Laurel, MD 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Carcinoma of Prostate, metastat
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D12583
29d. Date signed (Month, Day, Year): 2/16/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Louis Breschi 6830 Hospital Drive St. 204 Balto. Md 21237

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04813

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mildred M Dotterweich
2. Date of Death (Month, Day, Year): Feb. 18 2001
3. Time of Death: 11:10am
4a. Facility Name (If not institution, give street and number): 612 Maryland AVE.
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-30-7707
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 10 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 612 Maryland AVe.
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Harry C Griffin
18. Mother's Name (First, Middle, Maiden Surneme): Anna Dvorak

19a. Informant's Name/Relationship (Type, Print): Mary Bankard / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 612 Maryland AVe. Baltimore Md 21221

20e. Method of Disposition: 1☒ Burial 2☐ Cremelion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Holly Hill CEmetery
Dete: 2/22/01
20c. Location - City or Town, State: Baltimore MD.

21. Signature of Funeral Service Licensee: R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD 21221

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARCINOMA OF THE LUNG — 6 MOS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Hypertension

Dementia

Arteriosclerotic Heart Disease

23b. Did tobacco use contributa to tha cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D17728
29d. Date signed (Month, Day, Year): 2/19/01

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print): Ba Yin Oung, M.D. 8022 Belair Rd. Balto., MD 21236

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04814

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Ida Elizabeth Davis | Feb. 15, 2001 | 0124 M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-28-5199 | 1☐M 2☒F | 70 Yrs. | | | May 7, 1930 | Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | BALTIMORE | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4112 Oakford Ave | 21215 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 7TH GRADE | | HOUSEKEEPING | St. Agnes Hospital |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| HERBERT STEPPE | ANNA LAWSON |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 |
|---|---|
| SHEILA SMITH / DAUGHTER | 8127 Scotts Level Road Pikesville, Md |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) ENTOMBMENT | KING MEMORIAL PARK | 2/20/01 | WOODLAWN, Maryland |

21. Signature of Funeral Service Licensee: ▶ Gary Harris

22. Name and Address of Facility: Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiorespiratory arrest

Due to (or as a consequence of):
b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Obesity

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mona Sofrey

29c. License number: D24476

29d. Date signed (Month, Dey, Year): Feb 19 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NISHA SOFREY 2300 Garrison Blvd Balto MD 21216

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: ▶ G Sparks

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04815

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY C. DOMZALSKI
2. Deta of Death Month FEB. Dey 16, Year 2001
3. Time of Death: 5:15 AM
4e Facility Name (If not Institution, give street and number): CANTON HARBOR NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Deeth: N/A

**Funeral Director**

5. Social Security Number: 216-14-7300
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/4/14
9. Birthplece (State or Foreign Country): MD

Usuel Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 803 S. PORT ST.
10f. Zip Code: 21224
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 7; College (1-4or 5+): 0
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): SEAMSTRESS
16b. Kind of Business/Industry: FACTORY

17. Fathar's Neme (First, Middle, Last): FRANK ACURI
18. Mother's Name (First, Middle, Maiden Sumame): BRIDGETTE MONDRA

19a. Informent's Neme/Relationship (Type, Pnint): MR. VINCENT DOMZALSKI
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 803 S. PORT ST. BALTO., MD. 21224

20a. Method of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other place): HOLY ROSARY CEME. Dete: 2/19/01
20c. Location - City or Town, State: DUNDALK, MD.

21. Signature of Funeral Service Licensee: ▶ Charles Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD. 21222

**Physician /Medical Examiner**

23a. Part1. Entar the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): e. CORONARY ARTERY DISEASE — 4 YR

Due to (or es a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:
b. DIABETES MELLITUS
Due to (or as e consequenca of):
c.
Dua to (or as e consequenca of):
d.

Part II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco uee contribute to the cause of death? 1☐ Yee 2☑ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☑ No
24b. Ware autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and manner as steted. 2☐ Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifiar: ▶ MD
29c. License number: D47945
29d. Date signed (Month, Day, Year): Feb 20 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HARIS ALEEM 9161 FRANKLIN SQUARE DRIVE BALTIMORE MD 21237

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signatura: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

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6

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04816

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ODIS DAMON

2. Date of Death (Month, Day, Year): FEBRUARY 14,01

3. Time of Death: 4:45am

4a. Facility Name *(If not institution, give street and number)*: 519 LOUDON AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 250-28-9244

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 77 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 09-19-1923

9. Birthplace *(State or Foreign Country)*: SC

Usual Residence of Decedant

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 519 LOUDON AVE

10f. Zip Code: 21229

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: STEEL WORKER

16b. Kind of Business/Industry: MANUFACTURING

17. Father's Name *(First, Middle, Last)*: CHARLIE DAMON

18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH GEE

19a. Informent's Name/Relationship *(Type, Print)*: JANICE DAMON, DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 519 LOUDON AVE, BALTIMORE, MD 21229

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WOODLAWN CEMETERY

Date: 2-20-01

20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: Willie Howell Jr

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO, MD 21207

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. carcinoma of the lung. — 8 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D21928

29d. Date signed *(Month, Day, Year)*: 2/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3459 ST JOHNS LN ELLICOTT CITY MD 21042

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04817

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James Edwards Davis Jr
2. Date of Death — Month: February Day: 16 Year: 2001
3. Time of Death: 8:15 A.m.
4a. Facility Name (If not institution, give street end number): Northwest Hospital Center
4b. City, Town, or Location of Death: N/A
4c. County of Death: Randallstown

**Funeral Director**

5. Social Security Number: 212 60 7991
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 47 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 11, 1953
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Owings Mills
10c. City, Town or Location: N/A
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 4722 Truffle Lane
10f. Zip Code: 21117
10g. Citizen of What Country?: U.S.A
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Operator
16b. Kind of Business/Industry: Communication
17. Father's Name (First, Middle, Last): James Edwards Davis, Sr
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Yarbough
19a. Informent's Name/Relationship (Type, Print): Hattie Richardson/Sister in Law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4112 Ronis Road Baltimore County, Maryland 21208
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park
Date: February 21, 2001
20c. Location - City or Town, State: Baltimore County, Maryland
21. Signature of Funeral Service Licensee: Maggalean Gilmore Henson
22. Name and Address of Facility: Maggalean Gilmore Henson, Mortician 5240 Reisterstown Road Baltimore, Maryland 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident
Due to (or as a consequence of):
b. Pulmonary Edema

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pace maker
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one) — Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: I.C.S - R.A.O.M.O.
29c. License number: D43462
29d. Date signed (Month, Day, Year): February 16, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Northwest Hospital Center Randallstown, Maryland

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 04818

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Germaine Eugenie Catherine Donnelly
2. Date of Death — Month: February Dey: 16, Year: 2001
3. Time of Death: 12:45pM

4a. Facility Name *(If not institution, give street and number)*: Mariner Health of Catonsville
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-28-9818
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 27, 1909
9. Birthplace *(State or Foreign Country)*: France

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Arbutus
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1027 Circle Drive
10f. Zip Code: 21227
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress
16b. Kind of Business/Industry: Clothing

17. Father's Name *(First, Middle, Last)*: Jean Julien Joseph Remont
18. Mother's Name *(First, Middle, Maiden Surname)*: Maria Gurelie Alescine August

19a. Informant's Name/Relationship *(Type, Print)*: Sharon Gildee - Friend
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1934 Londontowne Drive, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore National Cem.
Date: 2/20/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Ann Y. Zink
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Pneumonia — Due to (or as a consequence of): Influenza — 1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease. High Blood Pressure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Alejandro Mejia MD
29c. License number: D0058780
29d. Date signed *(Month, Day, Year)*: 2-16-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALEJANDRO MEJIA MD 405 Frederick Rd Baltimore 21228

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001
32. Registrar's Signature: D. Sparks

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black indelible ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04819

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Helen Dunn Donohue

2. Date of Death Month / Day / Year: February 15 2001

3. Time of Death: 10:20 AM

4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-10-3711

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 9, 1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5603 Roland Ave.

10f. Zip Code: 21210

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Alfred H. Dunn

18. Mother's Name *(First, Middle, Maiden Surname)*: Nellie Isanogle

19a. Informant's Name/Relationship *(Type, Print)*: John C. Donohue, Jr./son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5210 Patterson Farms Rd. Baldwin, MD 21013

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Druid Ridge Cemetery

Date: 2/19/01

20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: ▶ John O. Mitchell IV

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. multiple cerebral hemispheric strokes months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ W. Anthony Riley, MD

29c. License number: D25205

29d. Date signed *(Month, Day, Year)*: February 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley Gomez 6701 N. Charles St. Balto. Md 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: ▶ D. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2/15/01 10:20 Donahue, Helen

10

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04820

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Richard W. Davis | 02/14/2001 | 9:00 A M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Greater Baltimore Medical Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-20-9154 | 1 X M 2 ☐ F | 76 Yrs. | | | 08/10/1924 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Baltimore | Parkville | 1 ☐ Yes 2 XX No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8800 Walther Blvd. Unit #1615 | 21234 | United States |

| 11. Marital Status | 12. Wes Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WW II | 1 ☐ Yes 2 XX No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Printer | Owner |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| Archibald A. Davis | Helen Wilson |

| 19a. Informant's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Geraldine E. Davis/wife | 8800 Walther Blvd. Unit 1615 Parkville, MD 21234 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Hilltop Service Corp. | 02/17/2001 | Towson, Maryland |

21. Signature of Funeral Service Licensee: Carl L. Lange

22. Name and Address of Facility: Ruck Towson Funeral Home, inc. 1050 York Road Towson, Maryland 21204

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in death) | a. Perforated Intestine | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in death) Last | b. Due to (or as a consequence of): Lymphoma | |
| | c. Due to (or as a consequence of): Myelodysplastic Syndrome | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Wes decedent pregnant in the pest 12 months? | 23c. If yes, outcome of pregnancy | 23d. Dete of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnency 4 ☐ Pregnent at time of death 5 ☐ Other (specify) 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probebly 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were eutopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

| 25. Wes case referred to medical examiner? | 28. Place of Death (Check only one) |
|---|---|
| 1 ☐ Yes 2 X No | Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Yeer) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |

| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner es steted. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated.

| 29b. Signature end title of certifier | 29c. License number | 29d. Dete signed (Month, Day, Year) |
|---|---|---|
| Baldonza MD | D19166 | 2/15/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan J. Baldanza, M.D. 10629 York Rd. Cockeysville, Md. 21030

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 2 0 2001 | Geneva G Sparks |

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No: 2001 04821

Dell, Melvin

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Melvin W. Dell

2. Date of Death — Month: February Day: 16 Year: 2001

3. Time of Death: 12:00 A.M.

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-34-7143

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 62 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 8/12/1938

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 5704 Van Dyke Road

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Front End Manager

16b. Kind of Business/Industry: Supermarket

17. Father's Name *(First, Middle, Last)*: Melvin Dell

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian (Unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Dell

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5704 Van Dyke Road Baltimore, Maryland 21206

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery

Date: 2/19/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Exacerbation of Obstructive Lung Disease — 30 Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D28762

29d. Date signed *(Month, Day, Year)*: February 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Sunil Ahuja 9000 Franklin Square Drive Baltimore, MD 21237

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 2 0 2001

32. Registrar's Signature: [signature] G Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

10+1

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04822

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edward Evans
2. Date of Death: Month February Day 17 Year 2001
3. Time of Death: 3am
4a. Facility Name (If not institution, give street and number): North West Hospital
4b. City, Town, or Location of Death: Randallstown MD
4c. County of Death: Baltimore County

**Funeral Director**

5. Social Security Number: 219-40-2897
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 7, 1943
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1821 N. Smallwood St.
10f. Zip Code: 21216
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Isaiah Evans
18. Mother's Name (First, Middle, Maiden Surname): Annie Mae Furward

19a. Informant's Name/Relationship (Type, Print): (wife) Mrs. Edna Evans
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1821 N. Smallwood St. Balto. Md. 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge; Date: 2/22/2001
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in death)
a. SEPSIS — 7 days

Due to (or es e consequence of):
b. SUBMENTAL ABSCESS

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: ESRD

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the besis of examination and/or investigation, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D4049
29d. Date signed (Month, Dey, Year): FEBRUARY - 17 - 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Syed. M.A Riaz North west Hospital 5401 Old Court Rd. Randallstown 21133

**State Registrar**

31. Date filed (Month, Dey, Year): FEB 20 2001
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04823

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): IRA D. EBY
2. Date of Death: Month February, Day 13, Year 2001
3. Time of Death: 16:30
4a. Facility Name (If not institution, give street and number): Mariner Health of Furnace Branch
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 204-18-8895
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 4/16/25
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Millersville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8121 Foxwell Road
10f. Zip Code: 21108
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Crane Operator
16b. Kind of Business/Industry: R.E. Linder

17. Father's Name (First, Middle, Last): Paul R. Eby
18. Mother's Name (First, Middle, Maiden Surname): Elsie Yoder

19a. Informant's Name/Relationship (Type, Print): James L. Eby - son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8121 Foxwell Road, Millersville, MD 21108

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 2/14
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Kelly Gregory Fink
22. Name and Address of Facility: FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | CHRONIC LYMPHOCYTIC LEUKEMIA | 24 YEARS |
| Due to (or as a consequence of): b. | CEREBROVASCULAR ACCIDENT | 5 YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c. | ESSENTIAL HYPERTENSION | 24 YEARS |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harjit Singh M.D
29c. License number: D 14160
29d. Date signed (Month, Day, Year): FEBRUARY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HARJIT SINGH M.D 5410-A RITCHIE HIGHWAY, BALTIMORE, MARYLAND-21225.

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

4+1

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04824

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lucille Alice Erich

2. Date of Death Month / Day / Year: February 16, 2001

3. Time of Death: 6:23 P.M.

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 198-05-1240

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 30, 1920

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13 Elm Drive

10f. Zip Code: 21220

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Information Processor

16b. Kind of Business/Industry: ADP

17. Father's Name (First, Middle, Last): Charles R. Wieder

18. Mother's Name (First, Middle, Maiden Surname): Annie Mae Kulp

19a. Informant's Name/Relationship (Type, Print): Robert Albright Erich, Sr. (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Elm Drive, Baltimore, Maryland 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gardens

Date: 2/19/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Subdural hematoma — 36 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atrial fibrilation

Due to (or as a consequence of):

c. Anticoagulation

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stuart R. Willes MD.

29c. License number: D36663

29d. Date signed (Month, Day, Year): February 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Stuart R. Willes, 9000 Franklin Square Drive, Baltimore, Maryland 21237

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: [signature]

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**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Erich, Lucille

16

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04825

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Maggie Lou Fields

2. Data of Death Month Day Yaar: February 15 2001

3. Tima of Death: 0400

4a. Facility Name (If not institution, giva street and number): Future Care of Homewood

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 247-48-9311

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 74 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): March 6, 1926

9. Birthplace (State or Foraign Country): South Carolina

Usual Rasidanca of Decedant

10a. Stata: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 3223 Greenmead Rd.

10f. Zip Coda: 21244

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Marriad 2☐ Marriad 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Raca - American Indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highast grada compliatad): Elamentary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): Nurse's Assistant

16b. Kind of Business/Industry: Hospital

17. Fathar's Name (First, Middle, Last): Henry Dykes

18. Mothar's Nama (First, Middle, Maidan Surnama): Corine Riley

19a. Informant's Name/Relationship (Type/Print): Mr. Eddie Fields Jr. (Son)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1286 Ocean Parkway Berlin, Md. 21811

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): Arbutus Mem. Park

Date: 2/21/2001

20c. Location - City or Town, Stata: Balto. Md.

21. Signature of Funarel Servica Licensee: Joseph L. Russ

22. Nama and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one ceuse on eech lina.

Approximata Intarval Batween Onsat and Daath

Immediata Causa (Finel disaasa or condition rasulting in daath)

a. Severe Protein Calorie Malnutrition — unknown

Dua to (or as a consequance of):

b. Severe Dematia

Sequantially list conditions, if any, leeding to immadiata causa. Enter Underlying Cause (Disaasa or Injury that initiated avants resulting in death) Last

Dua to (or as a consequanca of):

c. Diabetes Mellitis

Dua to (or es e consequanca of):

d. Hypertension

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23b. Did tobacco uae contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarred to medical exeminar? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona)

Hospitel: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Homa 5☐ Residanca 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at tha tima, data end place, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha time, data end pleca, and due to tha causa(s) and mannar statad.

29b. Signature and title of certifier: Christopher M Price

29c. Licanse number: D43564

29d. Date signed (Month, Day, Year): February 16, 2001

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print): 3333 N. Calvert St., Ste 575, Baltimore, MD 21218

**State Registrar**

31. Data filed (Month, Day, Year): FEB 20 2001

32. Registrer's Signeture

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DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04826

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GEORGE S. FENWICK
2. Date of Death (Month, Day, Year): FEB. 15, 2001
3. Time of Death: 9:30 AM
4a. Facility Name (If not institution, give street and number): CARING CORNERS INC.
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 212-10-5631
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 26, 1908
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9217 ALLENWOODS ROAD
10f. Zip Code: 21133
10g. Citizen of What Country?: USA.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4TH GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LONGSHOREMAN
16b. Kind of Business/Industry: STEAMSHIP TRADE

17. Father's Name (First, Middle, Last): GEORGE H. FENWICK
18. Mother's Name (First, Middle, Maiden Surname): MARY F. BARNES

19a. Informant's Name/Relationship (Type, Print): HELEN JACOBS (NIECE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4515 MANORDENE RD., APT C, BALTO. MD. 21229

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST
Date: 02-21-01
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Robert Brown
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Acute Myocardial Infarction | 1 day |
| Due to (or as a consequence of): b. | Coronary artery Disease | 1yr |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | | |
| Due to (or as a consequence of): d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Parkinsonism

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. R
29c. License number: D25046
29d. Date signed (Month, Day, Year): 2/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. REHMAN M, 3800 W. BELVEDERE AVE, BALTO. MD. 21215

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04827

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CHESTER L FARMER SR.
2. Date of Death: Month FEBRUARY Day 11 Year 2001
3. Time of Death: 12:15 PM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 232-70-4757
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 55 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/12/45
9. Birthplace (State or Foreign Country): WEST VIRGINIA

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 439 ELRINO STREET
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
18b. Kind of Business/Industry: D&S PIPE

17. Father's Name (First, Middle, Last): FRED C. FARMER
18. Mother's Name (First, Middle, Maiden Surname): ELLA MARIE CANICK

19a. Informant's Name/Relationship (Type, Print): JACQUELINE FARMER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 439 ELRINO ST. BALTIMORE, MD. 21224

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT CEME.
Date: 2/16/01
20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: Charles Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD 21222

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Coronary artery disease
c. Due to (or as a consequence of): hypertension
d. Due to (or as a consequence of):

tF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D43546
29d. Date signed (Month, Day, Year): 2/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DARIUS RASTEGAR MD, Bayview Medical Center, 4940 Eastern Ave, Balto MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Geneva G Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04828

Clarence Foster

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Data of Death Month Day Yaar | 3. Tima of Daath |
|---|---|---|
| Clarence W. Foster | Feb. 17, 2001 | 10:27 PM |

| 4a. Facility Nama (If not institution, giva straat and number) | 4b. City, Town, or Location of Daath | 4c. County of Daath |
|---|---|---|
| Augsburg Lutheran Nursing Home | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Numbar | 6. Sax | 7. Aga (In yrs. last birthday) | If Undar 1 Year: Months / Days | If Undar 24 Hrs.: Hours / Min. | 8. Data of Birth (Month, Day, Yaar) | 9. Birthplace (State or Foraign Country) |
|---|---|---|---|---|---|---|
| 216-03-7272 | 1☒M 2☐F | 88 Yrs. | | | Sept. 25, 1912 | MD |

Usual Rasidance of Decedant

| 10a. Stata | 10b. County | 10c. City, Town or Location | 10d. Insida City Limits |
|---|---|---|---|
| MD | Anne Arundel | Severna Park | 1☐Yas 2☒No |

| 10e. Street and Number | 10f. Zip Coda | 10g. Citizan of What Country? |
|---|---|---|
| 173 Dundee Rd. | 21146 | U.S.A. |

| 11. Marital Status | 12. Was Dacadant Evar in U.S. Armed Forcas? | 13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) | 14. Raca - American Indian, Black, Whita, atc. |
|---|---|---|---|
| 1☐Navar Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yas 2☒No If Yas, Giva Yaar or Datas: | 1☐Yas 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Spacify only highast grada complatad) | | 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) | 16b. Kind of Businass/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | Collega (1-4or 5+) | | |
| 5 | | Labor | Manufactoring |

| 17. Fathar's Nama (First, Middle, Last) | 18. Mothar's Nama (First, Middla, Maidan Surnama) |
|---|---|
| Albert L. Foster | Mary Jane Gray |

| 19a. Informant's Name/Ralationship (Type, Print) | 19b. Mailing Address (Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda) |
|---|---|
| Lucie M. Foster, Wife | 173 Dundee Rd. Severna Park, MD. 21146 |

| 20a. Mathod of Disposition | 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) | Data | 20c. Location - City or Town, Stata |
|---|---|---|---|
| 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify) | St. Paul Cemetery | 2-20-01 | Violetville, MD |

| 21. Signatura of Funaral Sarvica Licansee | 22. Nama and Address of Facility |
|---|---|
| Rebecca Robinson | Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 |

To Be Completed by Funeral Director

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that ceused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Daath

Immediata Causa (Final disaasa or condition rasulting in daath)

a. Parkinsons Disaay

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in tha past 12 months? 1☐Yas 2☐No 9☐Unknown

23c. If yas, outcoma of pragnancy 1☐Liva birth 2☐Fatal death 3☐Ectopic pregnancy 4☐Pregnant at tima of daath 5☐Othar (specify) _____ 9☐Unknown

23d. Data of dalivary Month Day Year

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23a. Did tobacco use contributa to tha causa of death? 1☐Yas 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yas 2☑No

24b. Wara autopsy findings availabla prior to complation of causa of daath? 1☐Yas 2☐No

25. Was casa refarrad to madical examinar? 1☐Yas 2☑No

26. Placa of Daath (Chack only ona)
Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA
Othar: 4☑Nursing Home 5☐Rasidance 6☐Othar (Specify)

27. Manner of Daath 1☑Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not ba datarmined

28a. Data of Injury (Month, Day Yaar) N/A

28b. Tima of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Straat and Numbar or Rural Route Numbar, City or Town, Stata)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Cartifiar (Check only one) 1☒**Certifying Physician:** To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐**Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

| 29b. Signatura and title of cartifiar | 29c. Licansa number | 29d. Data signad (Month, Day, Yaar) |
|---|---|---|
| Harold Bass | D15872 | February 19 2001 |

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Typa, Print) Harold Bass 25 Main Street Reisterstown Maryland 21136

| 31. Data filad (Month, Day, Yaar) | 32. Registrar's Signatura |
|---|---|
| FEB 20 2001 | Received |

**State Registrar**

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04829

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): FRANCES A. FERTITTA
2. Date of Death (Month, Day, Year): FEB. 16, 2001
3. Time of Death: 5:30 A.M.
4a. Facility Name (If not institution, give street and number): 1820 EDGEWOOD ROAD
4b. City, Town, or Location of Death: LOCH RAVEN VILLAGE
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 216-14-3411
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/13/1916
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: LOCH RAVEN VILLAGE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1820 Edgewood Road
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- tt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Eduction (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2 YEARS
16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): PITRO MICELI
18. Mother's Name (First, Middle, Maiden Sumame): JOSEPHINE GUSSIO

19a. Informent's Name/Relationship (Type, Print): NANCY FERTITTA DAUGHTER
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1820 EDGEWOOD ROAD BALTIMORE, MD 21234

20a. Method of Disposition: 1☒ Buriat 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): DULANEY VALLEY MEM. GAR. | Date: 2/19/01
20c. Location - City or Town, Stete: COCKEYSVILLE, MD

21. Signature of Funeral Service Licensee: Heather N. Hays
22. Name and Address ot Fecility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediete Cause (Finat disease or condition resulting in death)
e. METASTATIC CANCER TO BONE — 2 MOS
Due to (or es a consequence of):
b. UNKNOWN PRIMARY

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or es e consequence ot):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: CCRONRY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy tindings eveilable prior to completion ot cause of deeth? 1☐ Yes 2☐ No

25. Wes case reterred to medicat examiner? 1☐ Yes 2☒ No

26. Place ot Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, tarm, street, tactory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and piece, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: Francis X. Carmody
29c. License number: D01373
29d. Date signed (Month, Dey, Yeer): 2/16/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS X CARMODY MD 7565 OSLER DRIVE TOWSON, MD

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signeture: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division of Vital Records, P.O. Box 68760,

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**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04830

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOSEPH WILLIAM FEUKA
2. Date of Death: Month FEB Day 16 Year 2001
3. Time of Death: 12:03 PM
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

**Funeral Director**

5. Social Security Number: 218-22-9300
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 18, 1926
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6B Swampscott Court
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: 1950-1967
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Demolition Truck Operator
16b. Kind of Business/Industry: Baltimore City

17. Father's Name (First, Middle, Last): Joseph William Feuka
18. Mother's Name (First, Middle, Maiden Surname): Veronica Roberts

19a. Informant's Name/Relationship (Type, Print): Theresa Kimpel (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 320 Stemmers Run Road, Essex, Maryland 21221

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gard. Date: 2/20/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. VENTRICULAR FIBRILLATION
Due to (or as a consequence of):
b. END STAGE CONGESTIVE HEART FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Altaha, M.D.
29c. License number: P 12555
29d. Date signed (Month, Day, Year): FEB 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMIN ALTAHA, M.D. 5601 LOCH RAVEN BOULEVARD, BALTIMORE, MD 21239-2995

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ELIZABETH GARNETT

2. Date of Death: Month FEBRUARY Day 19, Year 2001

3. Time of Death: 5 PM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 215-18-5006

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 15, 1911

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1933 Wheeler Avenue

10f. Zip Code: 21216

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Charlie Jordan

18. Mother's Name (First, Middle, Maiden Surname): Annie Mae Riddick

19a. Informant's Neme/Reletionship (Type, Print): Ms. Gertrude Brown

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1620 Winford Road, Baltimore, MD 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: Feb 23 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Gabriel L. Williams

22. Name and Address of Facility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: C. Ravi MD

29c. License number: D37333

29d. Date signed (Month, Day, Year): FEBRUARY 19, 2001

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21133

**State Registrar**

31. Date filed (Month, Dey, Year): FEB 20 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

AMEND ITEM: 5 PER F.H. G792 227-01 WR.

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04832

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Harold Goldsmith
2. Date of Death Month / Day / Year: February 6, 2001
3. Time of Death: 1018am
4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 251-16-6578
6. Sex: 1☒ M 2☐ F — unk
7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 7, 1908
9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 501 W. Franklin St.
10f. Zip Code: 21201
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced — unk.
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: unk
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Afro-American

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unemployed
16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: unk.
18. Mother's Name *(First, Middle, Maiden Surname)*: unk.

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Loretta Randolph (social worker)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 300 Metro Plaza Balto. Md. 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Zion — Date: 2/26/2001
20c. Location - City or Town, State: Lansdowne, Md

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Massive Gastrointestinal Bleed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: P 13520
29d. Date signed *(Month, Day, Year)*: 02/06/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John Adams, M.D. 40 Maryland General Hospital

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 2 0 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Harold Goldsmith
Baltimore, Maryland 21215-0020

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04833

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William E. Gibson
2. Date of Death: Month February Day 17 Year 2001
3. Time of Death: 17:44
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 244-04-5643
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 25, 1960
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10a. Street and Number: 323 Shagbark Road
10f. Zip Code: 21220
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Business Owner
16b. Kind of Business/Industry: Cleaning Service

17. Father's Name (First, Middle, Last): Stuart M. Gibson, Jr.
18. Mother's Name (First, Middle, Meiden Surname): Elizabeth McLaughlin

19a. Informent's Name/Relationship (Type, Print): Stuart M. Gibson, Jr./father
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3915 Walker Avenue Greensboro, NC 27403

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Metro Crematory, Inc.
Date: 2/19/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in deeth)
e. Sepsis — 9 Days

Due to (or es a consequence of):
b. Acquired Immunodeficiency Syndrome — 7 Years

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last
Due to (or es a consequence of):
c.

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Crohn's Disease
CMV / Cytomegalovirus Colitis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Piece of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the ceuse(s) and manner steted.

29b. Signeture and title of certifier: Krysten D. Fairbanks, MD
29c. License number: RES 000
29d. Date signed (Month, Dey, Year): February 17, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): 600 N. Wolfe Street, Baltimore, Maryland 21218

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: Donna G Sparks

ORIGINAL

DHMH 16 Rev 6/95

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04834

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Stephen Giernalczyk

2. Date of Death (Month, Day, Year): FEBRUARY 15, 2001

3. Time of Death: 05:12 PM

4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 060-26-0360

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08/04/1919

9. Birthplace (State or Foreign Country): Poland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10e. Street and Number: 2235 Quail Creek Court

10f. Zip Code: 21015

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician

16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Unknown Giernalczyk

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Myra DePasquale / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2235 Quail Creek Court Bel Air, Maryland 21015

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rosary Cemetery

Date: 2/19/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber

22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CARDIOGENIC SHOCK — 4 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Neal Reynolds

29c. License number: D 27163

29d. Date signed (Month, Day, Year): 2/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. NEAL REYNOLDS, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2001 FEB 20 PM 12:18

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04835

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): LOUELLA HARLEY GIBSON-KING

2. Date of Death (Month, Day, Year): February 14 2001

3. Time of Death: 10:30

4a. Facility Name (If not institution, give street and number): UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 216-14-0698

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 9 1922

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1800 HOLLINS STREET APT 207E

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): AIDE

16b. Kind of Business/Industry: ROSEWOOD HOSPITAL

17. Father's Name (First, Middle, Last): JAMES D. HARLEY

18. Mother's Name (First, Middle, Maiden Surname): LILLIE M WATKINS

19a. Informant's Name/Relationship (Type, Print): Carolyn Clark/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 255 N. Monroe St., Baltimore, Maryland 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore National Veteran Date: 2-20-01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: William C Brown

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W. NORTH AVENUE

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Bacterial pneumonia — 3 weeks

Due to (or as a consequence of):
b. Coronary artery disease — 1 month.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Benjamin MD

29c. License number: AT24389946

29d. Date signed (Month, Day, Year): February 14 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bethania Richards - 201 E. University Parkway - Baltimore - MD - 21218

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: Jessica G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 04836

Catherine E. Gieron

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| CATHERINE E. GIERON | February 15, 2001 | 5:00 P.M. M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 204 East Joppa Road Apt. 914 | Towson | Baltimore Co. |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-30-3195 | 1☐ M 2☒ F | 66 Yrs. | | | April 18,1934 | Havre de Grace,Md. |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore Co. | Towson | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 204 East Joppa Road Apt. 914 | 21286 | United State of America |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Bleck, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 3 | Registered Nurse | Nursing |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Howard E. Manley | Delia Marie O'Malley |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Dennis Anthony Gieron(Husband) | 204 East Joppa Road Apt. 914 Towson, Maryland 21286 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Dulaney Valley Mem.Gardens | 02/19/2001 | Timonium, Maryland |

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction — 10 min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASCUD

Due to (or as a consequence of):

c. Breast Cancer - stage 4

Due to (or as a consequence of):

d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐ Yes 2☒ No 9☐ Unknown | 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 26a. Date of Injury (Month, Day Year) | 26b. Time of Injury | 26c. Injury at Work? | 26d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Robert Turner MD | D53445 | 2/16/01, FEB 16 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT T. TURNER, MD. 7600 OSLER DR. SUITE 311 TOWSON, MD 21204

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar Amend Item #23a per PHYG800 10/29/01 EW

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04837

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Glen | Gillespie | February 19 2001 | 8:57 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Johns Hopkins Bayview | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 234-36-0685 | 1☒ M 2☐ F | 76 Yrs. | | | May 4, 1924 | West Virginia |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Dundalk | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7909 Trappe Road | 21222 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 8 Years | | Wire Worker | Steel Industry |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Glen G. Gillespie | Nannie V. Fleshman |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mattie Burton (Sister) | 7909 Trappe Road Dundalk, Maryland 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify) | Hilltop Service Corp. | 2/21/2001 | Towson, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Stephanie Massey | Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. multi-organ system failure

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): MYOCARDIAL INFARCTION
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Dete of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probebly 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Karen E. Boyle MD | P 1954 | February 19, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Karen Boyle, 4940 Eastern Avenue, Baltimore MD 21224

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04838

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: ESTELLE H, GATES
2. Date of Death Month Day Year: FEB. 16, 2001
3. Time of Death: 9AM
4a. Facility Name *(If not institution, give street and number)*: 3240 KENYON AVE.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 231-26-3945
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG.23,1915
9. Birthplace *(State or Foreign Country)*: S.CAROLINA

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3240 KENYON AVENUE
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10TH; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DIET AIDE
16b. Kind of Business/Industry: CITY HOSPITAL

17. Father's Name *(First, Middle, Last)*: ROBERT CONNOR
18. Mother's Name *(First, Middle, Maiden Surname)*: BESSIE

19a. Informant's Name/Relationship *(Type, Print)*: BEATRICE WALKER(daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3240 KENYON AVENUE, BALTO,MD. 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CEDAR HILL CEMETERY
Date: FEB.19,2001
20c. Location - City or Town, State: ANNE arundel co.

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO,MD. 21213

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. END STAGE ALZHEIMER'S DS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:
b. Due to (or as a consequenca of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D0033215
29d. Date signed *(Month, Day, Year)*: 02/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shirley Thompson Richards M.D. 7401 Osler Dr Ste 11 Towson MD 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001
32. Registrar's Signature: Regina G Sparks

ORIGINAL

DHMH 16 Rev 6/95

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-0747-510

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

TAMIKA A. HARRIS
ASP

For State Registrar 1- AMEND ITEM 1,23a,pt II,&27 per ME 4-30-01 SSS
AMEND ITEM: #16A PER F.H. G792, 2-20-01 WR

# State of Maryland / Department of Health and Mental Hygiene
# Certificate of Death

Reg. No. 2001 04839

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|
| Tamiki Arnita Harris ~~Tamiki A. Harris~~ | | FEBRUARY 09 2001 | 1:20 PM |
| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death | |
| 1132 N. LONGWOOD ST. | BALTIMORE | N/A | |

**Funeral Director**

| 5. Social Security Number | 8. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-96-1687 | 1☐M 2☒F | 23 Yrs. | | | June 19,1977 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1132 N. Longwood Street | 21216 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondery (0-12) | College (1-4or 5+) | SECURITY GUARD ~~Sevurity Guard~~ | Solidarity Security Agency |
| 11th grade | | | |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Gregory R. Harris | Ella A. Woodson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ella A. Johnson | 1132 N. Longwood Street Baltimore, Maryland 21216 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Woodlawn Cemetery | 2/16/2001 | Woodlawn, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Greg Harris | Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. DILATED CARDIOMYOPATHY | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown | |

Part II. Othar **significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

FATTY LIVER; MORBID OBESITY

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical exeminer? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE |

| 27. Menner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| ☒☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examinar**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] | O.C.M.E | FEBRUARY 10,2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Yeer) | 32. Registrar's Signature |
|---|---|
| FEB 2 0 2001 | [signature] |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04840

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Irma Hargis

2. Data of Death — Month: February Day: 14 Yaar: 2001

3. Tima of Death: 4:00 PM

4a Facility Name *(If not institution, give street and number)*: Northwest Hospital

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-22-4294

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Year)*: April 18, 1926

9. Birthplaca *(Stata or Foraign Country)*: Maryland

Usual Residanca of Decedent

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Insida City Limits: 1☒ Yas 2☐ No

10a. Street and Number: 13 Mainbrook Ct.

10f. Zip Coda: 21136

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No. If Yas, Giva Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- il Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - Amarican Indian, Black, Whita, atc. *Specify:* African American

15. Decedent's Education *(Specify only highast grada completed)*: Elamentary/Secondary (0-12): 12 Collaga (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Crossing Guard

16b. Kind of Businass/Industry: Balto. City

17. Fathar's Nama *(First, Middle, Last)*: James Gross

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Daisy Cook

19a. Informant's Name/Ralationship *(Type, Print)*: Ms. Jacqueline Foote (daughter)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 3629 Valley Terrace #4 Balto. Md. 21244

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatery, crematory or othar placa)*: Arbutus Mem. Park — Data: 2/21/2001

20c. Location - City or Town, Stata: Balto. Md.

21. Signatura of Funaral Sarvica Licansee: Joseph L. Russ

22. Nama and Addrass of Facility: Joseph L. Russ Funeral Home, 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Entar the disaasa, or complications that causa the death. Do not enter the moda of dying, such as cardiac or respiratory arrast, shock, or heart lailura. List only *ona* cause on each line.

Approximate Intarval Batwaan Onsat and Daath

Immadiata Causa (Final disaasa or condition rasulting in daath)

a. END STAGE RENAL DISEASE

Dua to (or as a consequence of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated avants rasulting in death) Last

b.

Dua to (or as a consequanca of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

DIABETES, SEPSIS, CHF

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yas 2☒ No

25. Was casa ralarrad to madical axaminar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Hama 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determinad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describa how injury occurrad

28a. Placa of Injury - At hama, farm, street, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of certifiar: C. Nni MD

29c. Licansa number: D37333

29d. Date signed *(Month, Day, Year)*: FEBRUARY 14, 2001

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Type, Print): C. NNI MD, NHC, BALTO. MD 21133

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 2 0 2001

32. Registrar's Signatura: Geneva G Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-0571-003
crn
Paris Haughton

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04841

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| PARIS HAUGHTON | January 21, 2001 | 1:24 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| North Arundel Hospital | Glen Burnie | Anne Arundel |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 421-34-9975 | 1☐M 2☒F | 70 Yrs. | | | Aug 29, 1930 | Alabama |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Anne Arundel | Pasadena | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8072 Pendragon Way | 21122 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: white |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | 1 | human resource asst | department store |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Payton Moore | Ida King |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Elizabeth Haughton/daughter | 8072 Pendragon Way Pasadena, MD 21122 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) in state | | | |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Ronald S. Wade, Director | State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrhythmia

Due to (or as a consequence of):
b. Atherosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Alcoholism
Breast Cancer

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Dennis Chutemo | O.C.M.E. | February 08, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chutemo 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 2 0 2001 | ▶ Geneva G Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04842

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Edith H. Harper

2. Date of Death: Month 02 Day 13 Year 2001

3. Time of Death: 10 PM

4a. Facility Name (If not institution, give street and number): Sharon Nursing Home

4b. City, Town, or Location of Death: Sandy Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 579-26-5951

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04-26-1911

9. Birthplace (State or Foreign Country): Kansas

Usual Residence of Decedent

10a. State: MD. | 10b. County: Howard | 10c. City, Town or Location: Clarksville | 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13718 Pasture Green | 10f. Zip Code: 21029 | 10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary-US State Dept.

16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): James D. Hall

18. Mother's Name (First, Middle, Maiden Surname): Inez B. Elder

19a. Informant's Name/Relationship (Type, Print): Clarke B. Harper-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13718 Pasture Green, Clarksville, MD., 21029

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Parklawn Cemetery | Date: 02-19 2001

20c. Location - City or Town, State: Rockville, MD.

21. Signature of Funeral Service Licensee: [signature] 2/20/01

22. Name and Address of Facility: Fleck Funeral Home 2001 Sandy Spring Rd., Laurel, MD. 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE THROMBOEMBOLISM — ONE DAY

Due to (or as a consequence of):
b. MYOCARDIAL INFARCTION — ONE DAY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CARDIOVASCULAR DISEASE — YEARS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
VASCULAR DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] ATTENDING PHYSICIAN

29c. License number: D42046

29d. Date signed (Month, Day, Year): February 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GRACE BROOKE HUFFMAN, M.D. 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 20860

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: [signature] D. Sparks

10

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04843

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Marie Wagner
2. Data of Death Month / Day / Yaar: 02 / 18 / 2001
3. Time of Death: 6:30 PM
4a. Facility Name *(If not institution, give street and number)*: Frederick Villa Nursing Home
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Maryland

**Funeral Director**

5. Social Security Number: 214-14-3894
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 05-04-1905
9. Birthplace *(State or Foraign Country)*: Maryland

Usual Residence of Decedent

10a. Stata: Maryland
10b. County: Baltimore
10c. City, Town or Location:
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 5505 Forest Park Avenue
10f. Zip Coda: 21207
10g. Citizan of What Country?: USA
11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White
15. Decedent's Education *(Specify only highast grade completed)*: Elamentary/Secondary (0-12): 9th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Homemaker
16b. Kind of Business/Industry: Home
17. Fathar's Nama *(First, Middla, Last)*: Frederick Bolties
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Geneive Sattler
19a. Informant's Name/Relationship *(Type, Print)*: Joann Reed - daughter
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 1319 Middleford Road, Catonsville, MD. 21228
20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: New Cathedral Cemetery — Data: 02-21-2001
20c. Location - City or Town, Stata: Baltimore, MD.
21. Signature of Funaral Sarvice Licensee: Bernard Dalmata
22. Nama and Addrass of Facility: Witzke Funeral Home of Catonsville, 1630 Edmondson Ave., Catonsville, MD. 21228

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final diseasa or condition resulting in death)
a. pneumonia — respiration — 1wk

Dua to (or as a consequance of):
b. Parkinsons sclerotic disease — 5 yrs

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to compiation of ceusa ot death? 1☐ Yas 2☐ No

25. Was casa refarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Chack only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: [signature] Attn physician
29c. Licanse number: D29769
29d. Data signed *(Month, Day, Year)*: 2/20/01
30. Nama and addrass of parson who complatad ceusa of daath (Item 23a) (Type, Print): marcella D. Albuerne MD 516 N. Rolling Rd Balto Md 21228

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 20 2001
32. Registrar's Signatura: G. Soaks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04844

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Marie E. Haspert
2. Date of Death: Month Feb. Day 18, Year 2001
3. Time of Death: 5:45 am
4a. Facility Name (If not institution, give street and number): Saint Joseph Nursing Home
4b. City, Town, or Location of Death: Catonsville, MD
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212-32-8487
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 16, 1914
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1510 Latrobe Park Terrace
10f. Zip Code: 21230
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 15 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Healthcare

17. Father's Name (First, Middle, Last): Max Koehler
18. Mother's Name (First, Middle, Maiden Surname): Margaretha Heinrich

19a. Informant's Name/Relationship (Type, Print): Rose M. Lewandowski /Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1447 Towson Street, Baltimore MD 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory, or other place): The Most Holy Redeemer cem. Date: Feb. 21, 2001
20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
e. Conjestive Heart Failure
Due to (or as a consequence of):
Atherosclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alejandro Mejia MD
29c. License number: D0008780
29d. Date signed (Month, Day, Year): 2/19/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ALEJANDRO MEJIA MD. 405 Frederick Rd. Baltimore MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Penny D. Sparks

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04845

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): PEGGY J. HARGROVE
2. Date of Death (Month, Day, Year): February 15, 2001
3. Time of Death: 455p
4a. Facility Name (If not institution, give street and number): STELLA MARIS
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: 0

**Funeral Director**

5. Social Security Number: 220-16-8214
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 2, 1927
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 3942 BELVIEW AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): ALLEN TURNER
18. Mother's Name (First, Middle, Maiden Surname): VICTORIA TUCKER

19a. Informant's Name/Relationship (Type, Print): JAMES I HARGROVE / SPOUSE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3942 BELVIEW AVE. BALTIMORE, MD 21215

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): GARRISON FOREST VET. CEM.
Date: 2/22/01
20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: [signature] M01015
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL HM. 5151 BALTO. NAT'L PIKE BALTIMORE, MD 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. colon cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify): Hospice

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D70854
29d. Date Signed (Month, Day, Year): 2/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Rasberry 301 St Paul Pl Baltimore 21202

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: [signature] D. Sparks

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ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04846

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): MARIE Hudgins

2. Dete of Death: Month February Day 14 Year 2001

3. Time of Death: 11:31 PM

4a. Facility Neme (If not institution, give street end number): Northwest Hospital

4b. City, Town, or Location of Deeth: Randallstown

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-18-6386

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Daya

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): 10-25-1915

9. Birthplece (Stete or Foreign Country): MD.

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Baltimore

10c. City, Town or Location: Woodlawn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 3604 Landbeck Rd.

10f. Zip Code: 21207

10g. Citizen of What Country? USA

11. Maritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Black, White, etc. Specify: Black

15. Decedent'a Eduction (Specify only highest grade completed)

Elementery/Secondary (0-12): 11th Grade

College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: Housewife

17. Father's Neme (First, Middle, Last): Percy E. Lonesome

18. Mother's Name (First, Middle, Maiden Surneme): Grace Ambey

19a. Informent's Name/Reletionship (Type, Print): Ronald Hudgins / son

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1448 Maple Ave, Essex, MD. 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Loudon Park Cemetery

Dete: 2/19/01

20c. Location - City or Town, Stete: Balto. MD

21. Signeture of Funerel Service Licensee: Vaughn C Greene

22. Neme end Address of Facility: Vaughn C Greene Funeral Services 5151 Balto. Nat'l Pike Balto, MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complicetions thet ceused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in deeth)

e. lung cancer — 1 year

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last

b. Non-small cell carcinoma — 1 year

Due to (or as e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atherosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemineticn and/or investigetion, in my opinion, deeth occurred at the time, date and piece, end due to the ceuse(s) end menner stated.

29b. Signeture end litle of certifier: [signature] MD

29c. License number: D52746

29d. Dete signed (Month, Dey, Year): FEBRUARY 16, 2001

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): YELENA A. LIPNIK, MD. 720-C MAIDEN CHOICE LA. BALTO. MD 21228

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 20 2001

32. Registrer's Signeture: [signature]

ORIGINAL

DHMH 16 Rev 6/95

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**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04847

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Thornton Harden

2. Date of Death Month Day Year: FEBRUARY 18, 2001

3. Time of Death: 7:47 PM

4a. Facility Name (If not institution, give street end number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 256-26-1539

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 3, 1926

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1103 Mace Avenue

10f. Zip Code: 21221

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Detes: 1942 1956

13. Wes Decedent ot Hispenic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind ot Business/Industry: Corragated Box Company

17. Father's Neme (First, Middle, Last): Thornton Brown

18. Mother's Name (First, Middle, Maiden Surname): Daisy Turner

19a. Interment's Name/Relationship (Type, Print): Mrs. Leila Harden (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1103 Mace Avenue Essex, Maryland 21221

20a. Method ot Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)

20b. Plece ot Disposition (Neme of cemetery, cremetory or other piece): Gardens of Faith Cem.

Date: 2/22 2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funerel Service Licensee: [signature]

22. Name and Address of Fecility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode ot dying, such es cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final diseese or condition resulting in deeth): a. ISCHEMIC HEART DISEASE

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Last

b.

Due to (or as e consequence ot):

c.

Due to (or es e consequence ot):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco uae contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy tindings eveilable prior to completion of ceuse ot deeth? 1☐Yes 2☒No

25. Wes cese referred to medical examiner? 1☐Yes 2☒No

26. Plece ot Death (Check only one)

Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Menner ot Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time ot Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best ot my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner as stated. 2☐**Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: [signature]

29c. License number: D30263

29d. Date signed (Month, Dey, Year): 2-19-2001

30. Name and address of person who completed cause ot deeth (Item 23a) (Type, Print): FRANCIS KHOO, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

**State Registrar**

31. Dete tiled (Month, Dey, Year): FEB 20 2001

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

Thornton, Harden

6+1

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 04848

Hagerty, Darla

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Data of Deeth Month | Dey | Yeer | 3. Time of Death |
|---|---|---|---|---|---|---|
| Darla | Jean | Hagerty | February | 14 | 2001 | 1057am |

| 4a Facility Neme (If not institution, giva street and number) | 4b. City, Town, or Location of Death | 4c. County of Deeth |
|---|---|---|
| Franklin Square Hospital Center | Rosedale | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthdey) | If Under 1 Yeer Months | Days | If Under 24 Hrs. Hours | Min. | 8. Data of Birth (Month, Dey, Yeer) | 9. Birthpleca (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 212-48-4993 | 1☐ M 2☒ F | 54 Yrs. | | | | | Sept. 9,1946 | Maryland |

Usuel Residence of Decedent

| 10a. Stete | 10b. County | 10c. City, Town or Location | 10d. Insida City Limits |
|---|---|---|---|
| Maryland | Baltimore | Colgate | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 8000 Gough Street | 21224 | United States |

| 11. Maritel Status | 12. Was Decedent Evar in U,S. Armed Forces? | 13. Wes Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Merried 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Detes: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grada completed) | | 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondery (0-12) | Collega (1-4or 5+) | | |
| 12 Years | | Customer Service Rep. M.V.A. | Motor Vehicle Administration |

| 17. Father's Neme (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surneme) |
|---|---|
| John Robert Hagerty | Myrtle May Leitz |

| 19a. Informent's Name/Reletionship (Type, Print) | 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Glenn P. Evans (Son) | 3 Elinor Avenue Baltimore, Maryland 21236 |

| 20e. Method of Disposition | 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) | Dete | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify) | Oak Lawn Cemetery | 2/19/2001 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Nama and Addrass of Facility |
|---|---|
| ▶ [signature] | Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 |

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

| | | Approximete Intervel Between Onset end Deeth |
|---|---|---|
| Immedieta Cause (Final diseese or condition resulting in deeth) | a. Pulmonary Hypertension | 5 years |
| | Due to (or es e consequenca of): | |
| Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest | b. | |
| | Dua to (or as a consequenca of): | |
| | c. | |
| | Due to (or es a consequenca of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contributa to ths causas of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24e. Wes en eutopsy performed? | 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Wes casa referred to medical examiner? | 26. Place of Deeth (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify) |

| 27. Menner of Deeth | 28a. Date of Injury (Month, Dey Yeer) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) | | | 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) |

29e. Certifiar (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the cause(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, dete end placa, and due to the ceuse(s) and menner steted.

| 29b. Signeture end title of certifier | 29c. License number | 29d. Dete signed (Month, Dey, Yeer) |
|---|---|---|
| ▶ Stuart R. Willes, M.D. | D36663 | February 14 2001 |

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)
DR Stuart Willes 9000 Franklin Square Drive Baltimore Maryland 21237

**State Registrar**

| 31. Dete filed (Month, Dey, Yeer) | 32. Registrar's Signeture |
|---|---|
| FEB 20 2001 | ▶ Jenna G Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended ItemA#5 perFHG792 2/20/2001 EW

# Certificate of Death

Reg. No. 2001 04849

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Dete of Deeth Month | Dey | Yeer | 3. Time of Death |
|---|---|---|---|---|---|---|
| MARY | HOMMERBOCKER | | February | 14 | 2001 | 11:15 AM |

| 4a Facility Neme (If not institution, give street end number) | 4b. City, Town, or Location of Death | 4c. County of Deeth |
|---|---|---|
| JOHNS HOPKINS BAYVIEW HOSPITAL | BALTIMORE | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| ~~213-07-7855~~ 102-44-613 | 1☐ M 2☒ F | 101 Yrs. | | | | | 4/06/1899 | Maryland |

Usuel Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Dundalk | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 2909 Dunmurry Road Apt. C | 21222 | United States |

| 11. Meritel Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) | 14. Race - Americen Indian, Bleck, White, etc. |
|---|---|---|---|
| 1☐ Never Merried 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☐ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondery (0-12) | College (1-4or 5+) | | |
| 6 Years | | Housewife | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumeme) |
|---|---|
| Michael Haley | Sarah Legg |

| 19a. Informent's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dorothy M. Morgan (Daughter) | 8152 Del Haven Road Dundalk, Maryland 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify) | Cedar Hill Cemetery | 2/17/2001 | Baltimore, Maryland |

21. Signature of Funerel Service Licensee: Gregg E Ruck

22. Neme end Address of Fecility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

| | | Approximete Interval Between Onset end Death |
|---|---|---|
| Immediate Cause (Final diseese or condition resulting in death) | e. Acute Stroke | 4 days |
| | Due to (or es e consequence of): | |
| Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last | b. Myocardial Infarction | 4 days |
| | Due to (or es e consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was en autopsy performed? | 24b. Were autopsy findings available prior to completion of ceuse of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medicel exeminer? | 26. Place of Deeth (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| MD | RES001 | 2/14/2001 |

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print): Michael Schlosser 600 N. Wolfe St. Baltimore, MD 21218

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 2 0 2001 | Penny G Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04850

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Annie Lee Haynes

2. Date of Death — Month: FEB Day: 17 Year: 2001

3. Time of Death: 04:00

4e. Facility Name *(If not institution, give street end number)*: ST AGNES HEALTH CARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: 265-34-6147

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 05/28/1921

9. Birthplace *(State or Foreign Country)*: Georgia

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 3210 Garrison Blvd.

10f. Zip Code: 21216

10g. Citizen of Whet Country?: U.S.A.

11. Merital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* American Indian

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 5 College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Homemaker

17. Fether's Neme *(First, Middle, Last)*: Amire Sloan

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Nelly Graham

19e. Informent's Neme/Retetionship *(Type, Print)*: Charles Haynes / Son

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3210 Garrison Blvd., Baltimore, Maryland 21216

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Mt. Zion Cemetery

Dete: 02/24/01

20c. Location - City or Town, Stete: Landsdowne, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215

**Physician /Medical Examiner**

23e. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset and Deeth

Immediate Cause (Finet diseese or condition resulting tn deeth) a. RESPIRATORY FAILURE — 8days

Due to (or es e consequence of): COPD

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end ptece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end ptece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Appear MD

29c. License number: 14445

29d. Dete signed *(Month, Dey, Year)*: FEB, 17, 2001

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): LOUISA APPEA-DANQUAH, 900 CATON AVE, BALTIMORE MD

**State Registrar**

31. Dete filed *(Month, Dey, Year)*: FEB 2 0 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760**

**To the Hospital or Attending Physician:** The law requires that the death certificate be completed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

NAME ANNIE HAYNES

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04851

Jones, Ada

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Physician /Medical Examiner**

**Funeral Director**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month | Day | Year | 3. Time of Death |
|---|---|---|---|---|---|---|
| Ada | Jones | | February | 13, | 2001 | 5:55am |

| 4e. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore | N/A |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 214-20-3155 | 1☐ M 2☒ F | 97 Yrs. | | | | | Mar. 5, 1903 | S. Carolina |

**Usual Residence of Decedent**

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | N/A | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4108 Springdale Avenue | 21207 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 5th grade | | Housewife | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Sumeme) |
|---|---|
| Ben Townsend | Emma Shedrick |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Hannibal W. Jones/Husband | 4108 Springdale Avenue Baltimore, Maryland 21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment | Arbutus Memorial Park | 2/16/200 | Arbutus, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Gary Faus | Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | 6 days |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Gastric Ulcer perforation | 6 days |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Aidys Julia Valle M.D. | RES-000 | February 13, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sinai Hospital of Baltimore 2401 West Belvedere Avenue Baltimore Maryland

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 2 0 2001 | ▶ Geneva G Sparks |

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0925-510

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

EMMANUEL JONES

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04852

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Emanuel Lee Jones

2. Date of Death Month Day Year: FEBRUARY 17, 2001

3. Time of Death: 4:18P. M

4a. Facility Name (If not institution, give street and number): SHOCK TRAUMA CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-86-5681

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 30 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 26, 1970

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1513 N. Stricker St.

10f. Zip Code: 21217

10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed

16b. Kind of Business/Industry: Never Worked

17. Father's Name (First, Middle, Last): Emanuel Peter Jones

18. Mother's Name (First, Middle, Maiden Surname): Glenda Mack

19a. Informant's Name/Relationship (Type, Print) (mother): Mrs. Glenda Mack

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1513 N. Stricker St. Balto. Md. 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Mem. Park Date: 2/23/2001

20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Gunshot Wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 2/17/01

28b. Time of Injury: 1:45 PM

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street

28f. Location (Street and Number or Rural Route Number, City or Town, State): Baltimore, Md.

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner, M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): FEBRUARY 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001

32. Registrar's Signature: Denise G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04853

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Matilda V Jones.
2. Data of Death Month: 02 Day: 16 Year: 2001
3. Time of Death: 4:15am
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia MD
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 041-09-0221
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): FEB 3, 1909
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3004 North Ridge Road
10f. Zip Code: 21043
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Anthony Vivirski
18. Mother's Name (First, Middle, Maiden Surname): Anna Klenarski

19a. Informant's Name/Relationship (Type, Print): Jacqueline Lord/ daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4396 Columbia Road Ellicott City, MD 21042

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Metro Crematory, Inc.
Date: 2/19/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute myeloid leukemia
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Cardiomyopathy
Coronary Artery Disease
Chronic obstructive Pulmonary Disease

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Kathleen M York-Smith
29c. License number: D37011
29d. Date signed (Month, Day, Year): 2-16-2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kathleen M York-Smith MD 9501 old Annapolis Rd Ellicott City MD 21042

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Deanna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**To Be Completed by Funeral Director**

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 01851

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARTHA MAE JACKSON

2. Date of Death: Month: Feb Day: 13, Year: 2001

3. Time of Death: 0230am

4a. Facility Name (If not institution, give street and number): UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-24-9989

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 05, 1928

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2121 WINDSOR GARDEN LANE

10f. Zip Code: 21207

10g. Citizen of What Country?: USA.

11. Marital Status: 1☐ Naver Merried 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12TH GRADE; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UNIT CLERK

16b. Kind of Business/Industry: MERCY HOSPITAL

17. Father's Neme (First, Middle, Last): EVERETT SHERMAN

18. Mother's Neme (First, Middle, Maiden Sumeme): TRYPHENA

19a. Informent's Name/Relationship (Type, Print): TRYPHENA ROBINSON (DAUGHTER)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 34 STONECROFT RD., BALTIMORE, MD. 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other piece): LOUDON PARK CEMETERY Date: 02-16-01

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensea: J. H. Brown

22. Nama and Addrass of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD. 21217

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

| | | Approximate Intervel Between Onset and Deeth |
|---|---|---|
| Immediate Ceuse (Finel diseese or condition resulting in deeth) a. | Pulmonary Hemorrhage | 4 hours |
| Due to (or as a consequence of): b. | Acute Myocardial Infarction | 4 days |
| Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events rasulting in deeth) Last Due to (or as a consequence of): c. | Coronary Arterydisease | 7 years |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to complation of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end pleca, end due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: D. K. Kimble Jett, MD

29c. License number: D0025895

29d. Date signed (Month, Dey, Year): 2-13-01

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): G. Kimble Jett M.D. Union Memorial Hosp. Baltimore, MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001

32. Registrer's Signature: Denise G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

3

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04855

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY, ALICE JOBLING
2. Date of Death (Month, Day, Year): FEBRUARY, 16, 2001
3. Time of Death: 5:45 AM
4a. Facility Name (If not institution, give street and number): Vantage House Nursing Home
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 577-01-4609
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06/07/1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7402 Weather Worn Way
10f. Zip Code: 21046
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): LLoyd Haynie
18. Mother's Name (First, Middle, Maiden Surname): Helen L. Wilson

19a. Informant's Name/Relationship (Type, Print): Casey Jobling-daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7402 Weather Worn Way, Columbia, MD., 21046

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balti./Wash. Crematory | Date: 02/22/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Deloris M. Davis
22. Name and Address of Facility: Witzke Funeral Home Inc. 5555 Twin Knolls Road, Columbia, MD., 21045

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Cerebrovascular Disease — 3 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Flowers M.D.
29c. License number: D20789
29d. Date signed (Month, Day, Year): February 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Flowers MD 11055 Little Patuxent Columbia MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04856

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Luther Martin Jones

2. Date of Death (Month, Day, Year): February 16, 2001

3. Time of Death: 5:56am

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 213-09-3433

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04 20 06

9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1355 Stonewood Road

10f. Zip Code: 21239

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th grade; College (1-4or 5+): na

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Behtlehem Steel

17. Father's Name *(First, Middle, Last)*: John Jones

18. Mother's Name *(First, Middle, Maiden Surname)*: Rosa Jenkins

19a. Informant's Name/Relationship *(Type, Print)*: Luther L. Jones-Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1355 Stonewood Road, Baltimore Md 21239

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Marks Church Ceme

Date: 2/22/01

20c. Location - City or Town, State: Bayboro, N.C.

21. Signature of Funeral Service Licensee: Lola March

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Myocardial Infarction — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joanne Watson MD

29c. License number: AU4176435

29d. Date signed *(Month, Day, Year)*: February 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joanne Watson MD Union Memorial Hospital

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 2 0 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

4

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04857

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Haskey Barney Jester

2. Date of Death: Month FEBRUARY Day 14 Year 2001

3. Time of Death: 9:15PM

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

**Funeral Director**

5. Social Security Number: 214-76-7845

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min.

8. Date of Birth (Month, Day, Year): 07 11 59

9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: 3930 Dolfield Ave

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th grade; College (1-4or 5+): na

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Disable

16b. Kind of Business/Industry: Disable

17. Father's Name (First, Middle, Last): Raymond Jester

18. Mother's Name (First, Middle, Maiden Surneme): Bessie Hawthorne

19a. Informent's Name/Relationship (Type, Print): Bessie Jester-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3930 Dolfield Ave, Baltimore Md 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): Garrison Forest Vet.

Dete: 2/21/01

20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Bifneral Service Licensee: [signature]

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. lactic acidosis — 3 days

Due to (or es a consequence of): AIDS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest

b. Due to (or es a consequence of): Acute Renal Failure

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted. 2 [ ] **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: [signature], MD

29c. License number: RES - 000

29d. Date signed (Month, Day, Year): February 14, 2001

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): GUNNAR E SJOWALL, MD SINAI HOSPITAL OF BALTIMORE

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

At hum 9: Haskey Jester

6 + 1

01-0826-005
mnmr
Bruce Jennings, Jr.

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04858

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Bruce Richard Jennings, Jr.
2. Date of Death (Month, Day, Year): February 13, 2001
3. Time of Death: 2037 p M
4a. Facility Name (If not institution, give street and number): 1165 Donington Circle
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 214-90-5807
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 26 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06/02/1974
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1165 Donington Circle
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Classic Car Restoration
16b. Kind of Business/Industry: Automotive

17. Father's Name (First, Middle, Last): Bruce Richard Jennings, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Margaret Moulton

19a. Informant's Name/Relationship (Type, Print): Margaret M. Jennings / mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11647 Beauchamp Road #75; Berlin, MD 21811

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery
Date: 2/17/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Peter V. Chang
22. Name and Address of Facility: Ruck Towson Funeral Home Inc. 1050 York Road Towson, MD 21204

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONTACT GUN SHOT WOUND OF HEAD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Yaar

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Daath (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) at scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 2/13/01
28b. Time of Injury: 2011 M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred: SUBSHOT SHOTSELF
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): AT HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1165 DONNGTON CIRCLE, TOWSON, MD

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): February 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04859

Donna Johnson

Baltimore, Maryland 21215-0036

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Donna Johnson
2. Date of Death (Month, Day, Year): February 11, 2001
3. Time of Death: 8:25 pm
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

**Funeral Director**

5. Social Security Number: 212-42-4221
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-13-1942
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1542 N. Carey St.
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Proof Reader
16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): Milton Barnes
18. Mother's Name (First, Middle, Maiden Surname): Mertina Banks

19a. Informant's Name/Relationship (Type, Print): Purnell Johnson / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1542 N. Carey St. Balto. MD. 21217

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Cemetery
Date: 2/20/01
20c. Location - City or Town, State: Baltimore MD.

21. Signature of Funeral Service Licensee: Vaughn C. Greene
22. Name and Address of Facility: Vaughn C. Greene Funeral Services 5151 Balto. Nat'l Pike Balto. MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Sepsis | |
| | Due to (or as a consequence of): b. Pneumonia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P Prabhakar M.D.
29c. License number: P13531
29d. Date signed (Month, Day, Year): 2/12/01.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Priya Prabhakar, M.D. c/o Maryland General Hospital

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: G. Sparks

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04860

DT known AS Henry Krause

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Henry Krause

2. Date of Death: Month FEBRUARY Day 15, Year 2001

3. Time of Death: 11:27 AM

4a. Facility Name (If not institution, give street and number): Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-01-5011

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 3, 1907

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: Alice Manor Nursing Home 2095 Rockrose Avenue

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unknown

16b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): Jacob Krause

18. Mother's Name (First, Middle, Maiden Surname): Eva Hahenberger

19a. Informant's Name/Relationship (Type, Print): Betty Menikheim

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 848 W. 37th Street Baltimore, Maryland 21211

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 2/19/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Tracy H. Carpenter

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cerebrovascular accident

Due to (or as a consequence of):
b. Deep ven thrombosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Congestive heart failure

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Degenerative Joint Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 31464

29d. Date signed (Month, Day, Year): 2/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHOALB A. HASHMI, 821 N. EUTAW ST Suite 308 Balt. MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

01-0818-510
ALFRED KING
ASP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMEND ITEM 23a,27 per ME G793 033001 SS

Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ALFRED L. KING

2. Date of Death Month Day Year: FEBRUARY 13 2001

3. Time of Death: 1416 M

4a. Facility Name (If not institution, give street and number): 2526 SHIRLEY AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 227-58-8803

6. Sex: 1 X M 2 F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-30-47

9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 X Yes 2 No

10e. Street and Number: 2526 SHIRLEY AVE

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PLUMBER

16b. Kind of Business/Industry: PLUMBING

17. Father's Name (First, Middle, Last): EDDIE MILLER

18. Mother's Name (First, Middle, Maiden Surname): DAISEY MILLER

19a. Informant's Name/Relationship (Type, Print): DAISEY MILLER/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4308 Liberty Heights ve., Baltimore, MD 21207

20a. Method of Disposition: X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): VOSHELL MEM. GARDEN Date: 2/17/2001

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: HARI P. CLOSE FUNERAL SERVICE, PA 709 TESSIER ST., BALTIMORE, MD 21201-1925

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ATHERSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 X Other (Specify) SCENE

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): FEBRUARY 14,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R FOWLER 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: [signature] G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04862

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): REGINALD KNIGHT
2. Date of Death (Month, Day, Year): FEBRUARY 14 2001
3. Time of Death: 08:47AM
4a. Facility Name (If not institution, give street and number): 2034 Walbrook Ave.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

**Funeral Director**

5. Social Security Number: 214-56-5657
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 50 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-20-1950
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 2034 Walbrook Ave.
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UKN.
16b. Kind of Business/Industry: UKN.

17. Father's Name (First, Middle, Last): Thessalom Knight
18. Mother's Name (First, Middle, Maiden Surname): Ernestine Foster

19a. Informant's Name/Relationship (Type, Print): Barbara Allen - girlfriend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2034 Walbrook Ave. 21217 Baltimore, Maryland

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woshell Cemetery
Date: 2/20/20
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Miller's Metropolitan Chapel P.C. Baltimore 21217 163910

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. acute myocardial Infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☑ No

25. Was cese referred to medical examiner? 1 ☑ Yes 2 ☐ No
26. Piece of Deeth (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☑ **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D18327
29d. Date signed (Month, Day, Year): Feb 16 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Moges Gebremariam 4660 Wilkens Ave Balto Md 21229

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

4

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04863

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOSEPHINE D. KRAVITZ

2. Date of Death: Month FEB. Day 15, Year 2001

3. Time of Death: 6:30 PM

4a. Facility Name (If not institution, give street end number): 6704 RAILWAY AVE.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 181-07-7953

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Yaar: Months / Days | If Undar 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/12/17

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6704 RAILWAY AVE.

10f. Zip Code: 21222

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 7 | College (1-4or 5+): 0

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Fether's Name (First, Middle, Last): JOSEPH DZERZYNSKI

18. Mother's Name (First, Middle, Maiden Surneme): SOFIE STEFANOWICZ

19a. Informant's Name/Relationship (Type, Print): MR. THOMAS KRAVITZ

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 411 GEORGE ST. BALTO., MD. 21201

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): SACRED HEART OF MARY | Dete: 2/19/01

20c. Location - City or Town, Stete: DUNDALK, MD.

21. Signatura of Funaral Service Licensee: Charles Kaczorowski

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD. 21222

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disaase or condition resulting in death)
a. Atherosclerotic cardiovascular disease — immediate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Last
b.

Due to (or as e consequence of):
c.

Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to ths causs of death? 1☐ Yss 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was casa refarrad to medical examiner? 1☒ Yes 2☐ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Routa Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner steted.

29b. Signature and title of certifier: Scott A. Feeser MD

29c. License number: D42232

29d. Date signed (Month, Day, Year): 2/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott A. Feeser 2112 Dundalk Ave Baltimore, MD 21222

**State Registrar**

31. Data filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signatura: Geneva G Spates

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that tha death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 17 PER F.H. G792 2-20-01 WR.

# Certificate of Death

Reg. No. 2001 04864

**Physician /Medical Examiner**

1. Decedent's Neme (First, Middle, Last): Sonia Kaplan
2. Dete of Deeth: Month February Dey 14 Yeer 2001
3. Time of Death: 2340
4a. Facility Neme (If not institution, give street end number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Deeth: Baltimore

**Funeral Director**

5. Sociel Security Number: 129-12-2636
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthdey): 82 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): AUG. 18, 1918
9. Birthplece (Stete or Foreign Country): RUSSIA

Usuel Residence of Decedent

10e. Stete: MD
10b. County: BALTIMORE
10c. City, Town or Location: RANDALLSTOWN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Streef and Number: 3554 CARRIAGE HILL CIRCLE #103
10f. Zip Code: 21133
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Sfetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Evar in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decadent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Fether's Neme (First, Middle, Last): ~~NATHAN~~ NATHAN FASMAN ~~FASSMAN~~
18. Mother's Neme (First, Middle, Maiden Sumeme): ZELDA FASMAN

19a. Informent's Name/Reletionship (Type, Print): HARRY KAPLAN / HUSBAND
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3554 CARRIAGE HILL CIRCLE #103 - RANDALLSTOWN, MD 21133

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other plece): OHEB SHALOM MEMORIAL PARK
Dete: 2/18/01
20c. Location - City or Town, State: REISTERSTOWN, MD

21. Signeture of Funerel Service Licensee: D Rogger
22. Neme end Addrass of Fecility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respirotory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset and Deeth

Immediate Ceuse (Finel disaasa or condition resulting in deeth):
e. Multiple organ system failure (renal, heart, lung) — days

Due to (or es e consequenca of):
b. Severe left ventricular dysfunction — years

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in daeth) Last

Due to (or es e consequence of):
c. Arterrosclerotic cardiovascular disease — years

Due to (or es e consequence of):
d. End stage chronic obstructive pulmonary disease — years

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of deeth?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the ceusa(s) end menner steted.

29b. Signeture and title of certifier: D Rogger
29c. License number: D 35844
29d. Date signed (Month, Day, Yeer): February 15, 2001

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): D Roggen 5401 Old Court Road Randallstown MD 21133

**State Registrar**

31. Dete filed (Month, Dey, Yeer): FEB 20 2001
32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04865

Patient known as: Marsha Kopel

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | 2. Deta of Death Month | Dey | Year | 3. Time of Death |
|---|---|---|---|---|---|
| MARSHA | KOPEL | February | 14 | 2001 | 11:10pm |

| 4e Facility Neme (If not institution, give street end number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Sinai Hospital of Baltimore | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Yaar Months | Deys | If Undar 24 Hrs. Hours | Min. | 8. Date of Birth (Month, Dey, Yeer) | 9. Birthplece (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 215-42-0438 | 1☐ M 2☒ F | 56 Yrs. | | | | | JUNE 30,1944 | MD |

Usual Residence ot Decedent

| 10a. Steta | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | CARROLL | WESTMINSTER | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen ot Whet Country? |
|---|---|---|
| 945 OLD WESTMINSTER PIKE | 21157 | U.S.A. |

| 11. Marital Status | 12. Wes Decedent Ever in U.S. Armed Forces? | 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) | 14. Race - American Indien, Bleck, White, etc. |
|---|---|---|---|
| 1☐ Never Merried 2☐ Married 3☐ Widowed 4☒ Divorced | 1☐ Yes 2☒ No If Yes, Give Yeer or Detes: | 1☐ Yes 2☒ No Specify: | Specify: WHITE |

| 15. Decedent's Eduction (Specify only highest grade completed) | | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind ot Business/Industry |
|---|---|---|---|
| Elementery/Secondery (0-12) | College (1-4or 5+) | | |
| 12 | | HOMEMAKER | OWN HOME |

| 17. Fether's Neme (First, Middle, Last) | | 18. Mother's Name (First, Middle, Meiden Sumame) | |
|---|---|---|---|
| MANNIE | PERETZ | FREDA | FRANK |

| 19a. Interment's Neme/Reletionship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) |
|---|---|
| PAUL KOPEL / SON | 945 OLD WESTMINSTER PIKE - WESTMINSTER, MD 21157 |

| 20e. Method ot Disposition | 20b. Piece ot Disposition (Neme of cemetery, cremetory or other piece) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremetion 3☐ Removal trom State 4☐ Donetion 5☐ Other (Specify) | HAR SINAI BENEVOLENT | 2/16/01 | ROSEDALE, MD |

| 21. Signature of Funerel Service Licensea | 22. Neme end Address of Fecility |
|---|---|
| ▶ Edward C. Rusnak | SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 |

**To Be Completed by Funeral Director**

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part1. Enter tha diseese, or complications thet caused tha death. Do not enter the mode ot dying, such es cerdiac or respiretory arrast, shock, or heert teilure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest

b. Small Cell Lung Carcinoma

Dua to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Renal Failure

23b. **Did tobacco use contribute to the cause of death?** 1☒ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

| 24a. Was an autopsy performed? | 24b. Were autopsy findings evalleble prior to completion ot ceuse of deeth? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Wes cese referred to medicel examinar? | 26. Piece of Deeth (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Menner of Death | 28a. Dete of Injury (Month, Dey Yeer) | 28b. Time ot Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Piece ot Injury - At home, farm, street, fectory, office building, etc. (Specify) | 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) |
|---|---|
| | |

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best ot my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end plece, snd due to the ceuse(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Yeer) |
|---|---|---|
| ▶ MD | RES 000 | February 14, 2001 |

30. Neme and address ot person who completed ceuse ot deeth (Item 23a) (Type, Print) Sinai Hospital
Sinai Hospital 2401 West Belvedere Ave Baltimore m.A- 21215

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrer's Signeture |
|---|---|
| FEB 20 2001 | ▶ G. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04866

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BEVERLY KRAEMER
2. Data of Death: Month 02 Day 17 Year 01
3. Time of Death: 4:30PM
4a. Facility Name (If not institution, give street and number): University of Maryland Medical System
4b. City, Town, or Location of Death: Baltimore MD
4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 218-26-4984
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): NOV.5,1929
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 23 RANDALL AVENUE
10f. Zip Coda: 21208
10g. Citizen of Whet Country?: U.S.A.
11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Evar in U,S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grada complated): Elemantary/Secondary (0-12): 12; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): TIMEKEEPER
16b. Kind of Business/Industry: SOCIAL SECURITY ADMIN,
17. Fathar's Nama (First, Middla, Last): BERNARD HOFFMAN
18. Mothar's Nama (First, Middla, Maidan Surnama): ROSE COHEN
19a. Informant's Name/Reletionship (Type, Print): STANLEY KRAEMER / HUSBAND
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 23 RANDALL AVENUE - BALTIMORE, MD 21208
20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of camatary, cramatory or othar placa): CIRCLE BOBROISKER BENEFICIAL
Data: 2/19/01
20c. Location - City or Town, State: ROSEDALE, MD
21. Signatura of Funaral Sarvice Licensee: Robert Hammond
22. Nama and Addrass of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complicetions that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiretory arrast, shock, or heart failura. List only one ceuse on aach lina.

Approximata Intervel Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in daath)
a. Sepsis
Due to (or as a consequence of):
b. CML

Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last
Due to (or as a consequance of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Wara autopsy findings eveilable prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Home 5☐ Rasidanca 6☐ Othar (Specify)

27. Mennar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to the causa(s) and mennar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and manner stated.

29b. Signatura and titla of certifiar: Resident Physician
29c. Licansa number: P12361
29d. Data signed (Month, Day, Year): 2/17/01

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): Jill Allen, MD 22S Greene Street University of Maryland Medical System Baltimore, MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signatura: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04867

Lambert, Dolores

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Dolores M. Lambert
2. Date of Death (Month, Day, Year): FEBRUARY 15 2001
3. Time of Death: 12:25AM
4a. Facility Name *(If not institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 220-24-0252
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 15 1928
9. Birthplace *(State or Foreign Country)*: Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 112 Washington St.
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondery (0-12): 12
College (1-4or 5+): n/a
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Health Care Financing Administration
16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: John F. Roberts
18. Mother's Name *(First, Middle, Maiden Surname)*: Dorah Stroh

19a. Informant's Name/Relationship *(Type, Print)*: Ron W. Lambert/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 112 Washington St., Timonium, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Memorial Gardens
Date: 2/17/01
20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Michael J. Flagle
22. Name and Address of Facility: Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cerebral herniation — 7days
Due to (or as a consequence of):
b. acute epidural hematoma — 7days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Abetha MD
29c. License number: D0052278
29d. Date signed *(Month, Day, Year)*: 2/16/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Amiel Bethel 6569 N. Charles St Suite 403 Balt. MD 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 2 0 2001
32. Registrar's Signature: Geneva G Sparks

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

ADH
01-0837-005
BRELA LYNCH

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,b,27 per ME G794 040201 SS

# Certificate of Death

Reg. No. 2001 04868

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): BRELA' MILAN LYNCH
2. Date of Death: Month FEBRUARY Day 14, Year 2001
3. Time of Death: 0727 AM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 214-59-2163
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 0 Yrs.
If Under 1 Year: Months 4 Days
If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): SEPT 21, 2000
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: OWINGS MILLS
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 120 OWINGS GATE ROAD
10f. Zip Code: 21117
10g. Citizen of What Country? USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 0
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
18b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): REGGIE L. LYNCH
18. Mother's Name (First, Middle, Maiden Surname): GLORIA BODDIE

19a. Informant's Name/Relationship (Type, Print): REGGIE & GLORIA LYNCH (PARENTS)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 120 OWINGS GATE RD., APT. 302 OWINGS MILLS, MD 21117

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): KING MEMORIAL
Date: 02-19-01
20c. Location - City or Town, State: WOODLAWN, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. PNEUMONIA
Due to (or as e consequence of):
b. STREPTOCOCCAL BACTEREMIA
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. Licanse number: OCME
29d. Date signed (Month, Day, Year): FEBRUARY 15, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LARSN LOCKE MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 01869

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Pauline E. Lyle

2. Date of Death (Month, Day, Year): FEBRUARY 10, 2001

3. Time of Death: 5:59 PM

4a. Facility Name (If not institution, give street and number): MERCY MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 213-26-9810

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 16, 1930

9. Birthplace (State or Foreign Country): MD

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3504 Greenspring Avenue

10f. Zip Code: 21211

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse's Aide

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): John Crawley

18. Mother's Name (First, Middle, Maiden Surname): Betty Mason

19a. Informant's Name/Relationship (Type, Print): Mr. Ron Lyle-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3504 Greenspring Avenue, Baltimore, MD 21211

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: Feb 20 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Calvin L. Williams

22. Name and Address of Facility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GASTROPARESIS — WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marvin Lamar Bryant, Jr. MD

29c. License number: P13366

29d. Date signed (Month, Day, Year): February 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LAMAR BRYANT, MD 301 SAINT PAUL PLACE BALTIMORE, MD 21202

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: Penni N Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No 2001 04870

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: **Roger Milton Lagow**

2. Date of Death Month Day Year: Feb 17, 2001

3. Time of Death: 10:47a.m.

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 214-58-3497

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 49 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 31, 1951

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 10231 Carroll Place

10f. Zip Code: 20895

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Construction

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Herman Edward LaGow

18. Mother's Name *(First, Middle, Maiden Surname)*: Rita Bridal

19a. Informant's Name/Relationship *(Type, Print)*: Ms. karen Sheplee

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9402 Indigo Ct. Columbia, Maryland 21046

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: All County Cremation Services, Inc.

Date: 02/19/01

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: [signature] M00533

22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiratory errast, shock, or heart failura. List only one ceuse on eech tina.

Approximate Intarval Batween Onset and Death

Immediate Ceuse (Finet disease or condition resulting in death)

e. Sepsis

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immedieta cause. Enter Underlying Ceuse (Diseese or injury thet initieted events rasulting in death) Last

b. Acute Renal Failure

Due to (or es e consequenca of):

c. Multiple Sclerosis

Due to (or es a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ **Yes** 2 ☒ **No** 3 ☐ **Probably** 4 ☐ **Unknown**

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpetient 3 ☐ DOA. Othar: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be datermined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the tima, data and place, and due to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and pleca, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: [signature] MD

29c. Licensa number: D41624

29d. Date signed *(Month, Day, Year)*: 2-17-01

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): P. Murphy, MD. 1500 Forest Glen Rd. Silver Spring, MD 20910

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 2 0 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04871

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOHN LEWIS
2. Date of Death (Month, Day, Year): FEBRUARY, 18, 01
3. Time of Death: 8:25AM
4a. Facility Name (If not institution, give street and number): Northwest Hospital
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 226-40-8702
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-19-1932
9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 5422 Whitlock Rd.
10f. Zip Code: 21229
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade | College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): James H. Lewis
18. Mother's Name (First, Middle, Maiden Surname): Rosa Mae Blunt

19a. Informant's Name/Relationship (Type, Print): Jacqueline Lewis / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5422 whitLock Rd. Balto. MD. 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. Zion Cemetery | Date: 2/23/01
20c. Location - City or Town, State: Lansdowne, MD.

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name and Address of Facility: Vaughn C. Greene Funeral Services 5151 Balto. Nat'l Pike Balto. MD. 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC ESOPHAGEAL CANCER
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ K.S. RAO. M.D.
29c. License number: 043462
29d. Date signed (Month, Day, Year): FEBRUARY 18, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K.S. RAO. M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04872

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Margaret M. Lynch
2. Date of Death: Month 2 Day 18 Year 01
3. Time of Death: 12:30A
4a. Facility Name (If not institution, give street and number): Genesis Perring Parkway
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-74-5117
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 25, 1909
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5116 Ardmore Way
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): George S. Mann
18. Mother's Name (First, Middle, Maiden Surname): Lula Carnan

19a. Informant's Name/Relationship (Type, Print): William R. Lynch-Brother-in-Law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5116 Ardmore Way, Baltimore, MD 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 2/20/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: William G. Dau
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Senile Dementia — years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart failure Dysphagia Parkinsonism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Martha C. Raymundo
29c. License number: D54518
29d. Date signed (Month, Day, Year): 2/19/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): martha c. raymundo 3007 E. Northern Parkway Baltimore MD 21214

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: Spanks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04873

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANTHONY LABUE

2. Data of Death — Month: FEB Day: 14 Year: 2001

3. Time of Death: 7:05 PM

4a. Facility Name (If not institution, give street and number): MERCY HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 188-20-5298

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): Sept. 22, 1928

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8425 Old Harford Road Apt. D

10f. Zip Code: 21234

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Raca - American Indian, Black, White, etc. Specity: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner

16b. Kind of Business/Industry: Dry Cleaners

17. Father's Neme (First, Middle, Last): Pasquale LaBue

18. Mother's Name (First, Middle, Maiden Surnema): Cora Randazzo

19a. Informent's Neme/Relationship (Type, Pnnt): Mrs. Irma M. LaBue / Wife

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 8425 Old Harford Road Apt. D Parkville, MD 21234

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Moreland Mem. Park

Date: 2/19/2001

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funeral Service Licensee: Michael E. Canapp

22. Name and Address of Facility: LEONARD J. RUCK, INC. 5305 Harford Road Baltimore, MD 21214

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — 4 Days

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other elgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cauee of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Were autopsy findings available prior to compiation of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☒ No

26. Place of Deeth (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Placa of Injury - At homa, farm, straet, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 ☒ **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 ☐ **Medicat Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Costa, MD

29c. License number: D42634

29d. Date signed (Month, Day, Year): Feb 14, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH COSTA 301 ST PAUL PLACE BALTIMORE 21202

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.

**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exam- er must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attanding Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04874

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: VIVIAN A. LUTZ
2. Data of Death (Month, Day, Yaar): FEB. 13, 2001
3. Tima of Death: 1:00PM
4a. Facility Nama *(If not institution, give street and number)*: 403 S. JOPLIN STREET
4b. City, Town, or Location of Daath: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Sacurity Number: 220-09-4922
6. Sex: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: MAR. 22, 1920
9. Birthplaca *(Stata or Foraign Country)*: MD.

Usual Rasidanca of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 403 S. JOPLIN STREET
10f. Zip Coda: 21224
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Dacedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Raca - Amarican Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grade completed)*: Elamantary/Secondary (0-12): 12TH — Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratirad)*: CLERK
16b. Kind of Businass/Industry: SOCIAL SECURITY

17. Fathar's Name *(First, Middle, Last)*: HENRY MURDOCK
18. Mothar's Name *(First, Middle, Maidan Surnama)*: ANNA MILLER MURDOCK

19a. Informant's Name/Ralationship *(Type, Print)*: SHARON SQUILACE/DAUGHTER
19b. Mailing Addrass *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 217 QUAKER RIDGE RD., TIMONIUM, MD.21093

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: BALTIMORE WASHINGTON CREMATORY — Data: 2/15/01
20c. Location - City or Town, Stata: LAUREL, MD.

21. Signature of Funeral Service Licensee: Elizabeth Selenicki
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

**Physician /Medical Examiner**

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarvat Batween Onset and Death

Immediata Causa (Finat disaasa or condition resulting in daath)
a. Lung Carcer — Dua to (or as a consaquance of):
b. — Dua to (or as a consaquance of):
Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated evants resulting in daath) Last
c. — Dua to (or as a consaquanca of):
d.

Approximata Intarval Batween Onset and Death: 4 1/2 mos

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: Superior Vena Cava Syndrome

23b. Did tobacco uae contributa to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of cause of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical axaminar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☒ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Placa of Injury - At homa, farm, street, factory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar statad.

29b. Signature and title of certifier: Rodrigo B. Erlich M.D.
29c. License number: D54911
29d. Data signad *(Month, Day, Year)*: 02-14-01

30. Nama and address of parson who completed causa of daath (Item 23a) (Typa, Print): Rodrigo B. Erlich - 4940 Eastern Ave. - Baltimore MD 21224

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 2 0 2001
32. Registrar's Signatura: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04875

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Cynthia E Mucci
2. Date of Death Month: 2 Day: 15 Year: 2001
3. Time of Death: 13:15
4a. Facility Name (If not institution, give street and number): 8045 Round Moon Circle
4b. City, Town, or Location of Death: Jessup
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 237-27-6369
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 40 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 6, 1960
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Jessop
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8045 Round Moon Circle
10f. Zip Code: 20794
10g. Citizen of What Country? United States of America

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 4 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Programmer
16b. Kind of Business/Industry: Compter Science / Space Techology

17. Father's Name (First, Middle, Last): Thomas Eugene Brown
18. Mother's Name (First, Middle, Maiden Surname): Mildred Ann Wheeler

19a. Informant's Name/Relationship (Type, Print): David R Mucci
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8045 Round Moon Circle Jessop, Md 20794

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomic Gift Foundation Date: 2-15-01
20c. Location - City or Town, State: Laurel, Md

21. Signature of Funeral Service Licensee: ▶ BTOS
22. Name and Address of Facility: Anatomic Gift Foundation 13948 Baltimore Ave, Laurel Md 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast Cancer to the Lungs — 1½ years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Nicholas Int. Routzahn MD
29c. License number: D38509
29d. Date signed (Month, Day, Year): 2-20-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nicholas Int. Routzahn 11665 Little Patuxent Pky, Columbia MD 21044

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: ▶ D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04876

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): James R Mangan
2. Date of Death (Month, Day, Year): February 16 2001
3. Time of Death: 02:45
4a. Facility Name (If not institution, give street and number): Baltimore VA Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 212-26-3548
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 21, 1929
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3939 Roland Avenue Apt. LL9
10f. Zip Code: 21211
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1951-53
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Railroad Brakeman
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Patrick Mangan
18. Mother's Name (First, Middle, Maiden Surname): Kathleen Watson

19a. Informant's Name/Relationship (Type, Print): John Mangan Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7794 Hickory Road Stewartstown, PA 17363

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland VA Cemetery
Date: 2/20/01
20c. Location - City or Town, State: Garrison Forest, MD

21. Signature of Funeral Service Licensee: Jean R Carpenter
22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: MD
29c. License number: P12417
29d. Date signed (Month, Day, Year): February 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jean R Hou 22 S. Greene Street, Baltimore, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04877

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EDWARD C. MITCHELL

2. Date of Death: Month 2 Day 17 Year 2001

3. Time of Death: 9:10 Am

4a. Facility Name (If not institution, give street and number): LORIEN NURSING HOME

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-62-4040

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 47 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-15-53

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1713 E. FEDERAL ST

10f. Zip Code: 21213

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECURITY OFFICIER

16b. Kind of Business/Industry: SECURITY

17. Father's Name (First, Middle, Last): SYLVESTER BARNES

18. Mother's Name (First, Middle, Maiden Surname): MARY THOMAS

19a. Informent's Name/Relationship (Type, Print): SELMA PRESTON, SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1522 E. BALTO. ST 1ST FL, BALTO. MD 21231

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Nama of cemetery, crematory or other place): METRO CREMATORY

Date: 2-20-01

20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensaa: Willie E. Howell Jr

22. Nama and Address of Facility: HOWELL FUNERAL HOME 4600 Liberty Hghts Ave, Balto, Md 21207

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after daath with tha Maryland Department of Health and Mental Hygiana.

**Important: If item 27 is marked othar than "natural', or items 23a or 28a-f show any injury or other traumatic evant, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acquired Immunodeficiency Syndrome — 10 years

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. ____ Due to (or as a consequence of):

c. ____ Due to (or as a consequence of):

d. ____

Part II. **Other elgnificent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performad? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Other: 4 [X] Nursing Homa 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) end menner as steted. 2 [ ] **Medical Examinar:** On the besis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chi-Shiang Chen MD

29c. Licanse number: D-18151

29d. Date signed (Month, Day, Year): Feb. 19, 2001

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): CHI-SHIANG CHEN 301 ST. PAUL PLACE BALTIMORE MD 21202

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: Geneva G Sparks

**To the Hospital or Attending Physician:** The law raquires that the death certificata be executed within 24 hours after death.

**To the Funeral Director:** After this certificata has bean signed by tha attending physician and completaly filled in by tha funaral director, paga 2 should be datachad for use as tha burial-transit

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amend Item#5 perINFG793 3/23/2001 EW

# Certificate of Death

Reg. No. 2001 04878

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Catherine M. McGuirk

2. Data of Death Month Day Year: February 15, 2001

3. Tima of Death: 11:25 AM

4a Facility Nama (If not institution, giva street and number): Gilchrist Center for Hospice Care

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 220-05-5664 ~~212-05-5157~~

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 78 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): March 17, 1922

9. Birthplace (Stata or Foraign Country): Maryland

Usual Residence of Decedent

10a. Stata: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Linthicum Heights

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 709 East Maple Road

10f. Zip Code: 21090

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas: X

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): housewife

16b. Kind of Business/Industry: home

17. Father's Nama (First, Middla, Last): Henry G. Calvert

18. Mothar's Nama (First, Middle, Maiden Sumama): Catherine Steinacker

19a. Informant's Name/Ralationship (Type, Print): Patricia Vachino - daughter

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 17 Glen Dairy Court, Parkton, Maryland 21120

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar place): New Cathedral Cemetery

Data: 2/19/01

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Ann G Zink

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on aach lina.

Approximata Intarval Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in death)

a. rectal cancer — 1 year

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cesa referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Homa 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ J Anthony Riley, MD

29c. License number: D25205

29d. Data signed (Month, Day, Year): February 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signatura: ▶ G. Sparks

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No 2001 04879

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): IDA MARTINI

2. Date of Death: Month: February Day: 15 Year: 2001

3. Time of Death: 12:28

4a. Facility Name (If not institution, give street and number): Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-20-8751

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 28, 1926

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 714 Umbra St.

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 yrs.

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): David Lam

18. Mother's Name (First, Middle, Maiden Surname): Mary Breeden

19a. Informant's Name/Relationship (Type, Print): Karen Colosino daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3002 Dunbrin Rd. Baltimore Md. 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Date: Feb. 17, 2001

20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: John E. Mullen

22. Name and Address of Facility: Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Pulmonary Embolism — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: P9498

29d. Date signed (Month, Day, Year): February 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN BETHEA 8106 Alan Tree Rd. Baltimore, MD. 21237

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: [signature] G Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 04880

Feb 18, 2001

margaret morgan 9 50 AM

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

## Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret D. Morgan
2. Date of Death (Month, Day, Year): February 18, 2001
3. Time of Death: 9:50 A M
4a. Facility Name (If not institution, give street and number): Hospice of Baltimore Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

## Funeral Director

5. Social Security Number: 483-01-2187
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 3, 1917
9. Birthplace (State or Foreign Country): IOWA

## To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Sparks
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2001 Stringtown Road
10f. Zip Code: 21152
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edward Michael Drew
18. Mother's Name (First, Middle, Maiden Surname): Margaret Ellen Downey

19a. Informant's Name/Relationship (Type, Print): Frank Morgan/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2001 Stringtown Road Sparks, Maryland 21152

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glendale Cemetery
Date: 02/24/2001
20c. Location - City or Town, State: Des Moines, Iowa

21. Signature of Funeral Service Licensee: Stephen D. Coster
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

## Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cancer of the uterus — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as e consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

## Medical Certification; To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Helen M Gordon MD
29c. License number: D0051926
29d. Date signed (Month, Day, Year): Feb 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 6565 N. Charles St, Baltimore MD 21204 Helen M Gordon MD

## State Registrar

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Barbara G Jones

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black indelible ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04881

CHERYL MURPHY

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

## Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHERYL DIANE MURPHY
2. Date of Death (Month, Day, Year): FEB. 12, 2001
3. Time of Death: 11:30AM
4a. Facility Name (If not institution, give street and number): UNION MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

## Funeral Director

5. Social Security Number: 217-60-0852
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 48 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 28, 1952
9. Birthplace (State or Foreign Country): MD.

## To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4131 MARX AVE.
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12TH
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATION ASSISTANT
16b. Kind of Business/Industry: CATERING

17. Father's Name (First, Middle, Last): ROBERT VENZKE
18. Mother's Name (First, Middle, Maiden Surname): AUDREY UNKNOWN

19a. Informant's Name/Relationship (Type, Print): ELVA VENZKE/SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4131 MARX AVE., BALTIMORE, MD. 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKWOOD CEMETERY
Date: 2/15/01
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Richard J. Lemmon 100521
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

## Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC LUNG CANCER — ~1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus Type 2

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

## Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D40480
29d. Date signed (Month, Day, Year): February 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FERNANDO J. FERRO, 7672 Belair Road Baltimore MD 21236

10

## State Registrar

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: [signature] for D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04882

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| MARY | | MILNOVSKY | FEB. 13 2001 | 11:25AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 16 OLD COURT ROAD #404 | BALTIMORE | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| UNKNOWN | 1☐M 2☒F | 82 Yrs. | | | DEC.29,1918 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 16 OLD COURT ROAD #404 | 21208 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | SALES PERSON | DEPARTMENT STORE |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Neme (First, Middle, Maiden Surname) | |
|---|---|---|---|
| ABRAHAM | FOX | SOPHIA | BENNETT |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| SANDY WOLF / NIECE | 8017 VALLEY MANOR ROAD - OWINGS MILLS, MD 21117 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | BETH EL MEMORIAL PARK | 2/14/01 | RANDALLSTOWN, MD |

21. Signature of Funeral Service Licensee ▶ Jay Alan Levinson

22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute MI — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. HASCVD & Angina Pectoris — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHF, Renal Insufficeny

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24e. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ | D04701 | 2/13/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.H. MALINOW MD 3635 Old Court Rd Balto Md 21208

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | ▶ D. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04883

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Donald C. Oettinger
2. Date of Death (Month, Day, Year): February 15 2001
3. Time of Death: 17:41
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 217-14-5256
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10 04 1914
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: Md
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3450 Harrington Drive
10f. Zip Code: 21042
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Grocer/Self-employeed
16b. Kind of Business/Industry: Grocery Self-Employeed

17. Father's Name (First, Middle, Last): Rudolph E. Oettinger
18. Mother's Name (First, Middle, Maiden Surname): Emma Hickman

19a. Informant's Name/Relationship (Type, Print): Donna Broccolino/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4018 Pebble Branch Road, Ellicott City, Md 21042

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore-Washington Crem. | Date: 02/17/01 | 20c. Location - City or Town, State: Laurel, Md

21. Signature of Funeral Service Licensee: Peter L. Ashton Mgr II
22. Name and Address of Facility: Sterling-Ashton-Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure — Day of Death
Due to (or as a consequence of):
b. Ischemic cardiomyopathy — years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Advanced atherosclerosis — years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
probable lung cancer

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: HAOkun MD
29c. License number: D31172
29d. Date signed (Month, Day, Year): Feb 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HAOKUN 3460 ELLICOTT CENTER DR #03 ELLICOTT CITY MD 21043

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

CPS
01-0873-005
DARLENE OSTROWSKI

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEMS# 23,ptII&27 per ME 3/7/01 BS

# Certificate of Death

Reg. No. 2001 04884

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Darlene Sue Ostrowski | February 15, 2001 | 7:45 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 4 Enchanted Hills Apartment 101 | Owings Mills | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-60-8029 | 1☐M 2☑F | 47 Yrs. | | | 10/10/1953 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Owings Mills | 1☐Yes 2☑No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4 Enchanted Hill Road | 21117 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) | 14. Race - American Indian, Bleck, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced | 1☐Yes 2☑No If Yes, Give Year or Dates: | 1☐Yes 2☑No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 8th | | Homemaker | Domestic |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Sumame) |
|---|---|
| James Peyton | Vivian Robinette |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia Wiatrowski / daughter | 1417 Bank Street Baltimore, Maryland 21231 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☑Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify) | Bayview Crematory | 2/20/01 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| David J. Weber | David J. Weber Funeral Homes, P.A 401 S. Chester St. Baltimore, Md. 21231 |

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in death) | a. NARCOTIC USE COMPLICATING ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | |
| Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): b. | |
| | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CIRRHOSIS OF LIVER

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Theodore M. King MD | OCME | February 16, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

WAYNE EARL PULLIAM
01-0607-043
B.K.S

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

2001 04885

1- For State Registrar AMENDED ITEMS# 23,27,& 28a-f per MEC 02701-66 **Certificate of Death**

Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Wayne Earl Pulliam | FEB. 03 2001 | 8:20 PM M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| MARYLAND CORRECTIONAL INSTITUTION | HAGERSTOWN | WASHINGTON |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-92-6492 | 1 [X] M 2 [ ] F | 39 Yrs. | | | Aug. 31, 1961 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| VA | Fluvanna | Troy | 1 [ ] Yes 2 [X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| RR 2 Box 1290 | 22974 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: | 1 [ ] Yes 2 [X] No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Carpenter | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Earl Pulliam | Edith Grindstaff |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Edith Pulliam / mother | RR 2 Box 1290., Troy, VA 22974 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Chesapeake Crematory | 2/12/01 | Beltsville, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| M00986 | CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr. Towson, MD 21286 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. NARCOTIC INTOXICATION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1 [ ] Yes 2 [ ] No 9 [ ] Unknown | 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 [X] Yes 2 [ ] No | 1 [X] Yes 2 [ ] No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 [X] Yes 2 [ ] No | Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined | 2-3-01 | unknown M | 1 [ ] Yes 2 [X] No | unknown |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| jail cell | MARYLAND CORRECTIONAL INSTITUTE, HAGERSTOWN, MD |

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. Licanse number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| [signature] | O.C.M.E | FEB. 4, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Clifton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | Geneva B. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04886

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY PALMER

2. Date of Death (Month, Day, Year): FEBRUARY 18 2001

3. Time of Death: 19:07

4a. Facility Name (If not institution, give street and number): GOOD-SAMARITAN-HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 241-52-3246

6. Sex: 1☐ M 2☒ F

7. Age (in yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jul 3, 1924

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1132 North Dallas Street

10f. Zip Code: 21213

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nursing Assistant

16b. Kind of Business/Industry: Nursing Home

17. Father's Name (First, Middle, Last): James Edwards

18. Mother's Name (First, Middle, Maiden Surname): Fannie Easter

19a. Informant's Name/Relationship (Type, Print): Ms. Ruby Minor-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1832 North Dallas Street, Baltimore, MD 21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Grove Bapt.

Date: Feb 24 2001

20c. Location - City or Town, State: Gaston, NC

21. Signature of Funeral Service Licensee: Calvin L. Williams

22. Name and Address of Facility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARRYTHMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. AORTIC STENOSIS

Due to (or as a consequence of):

c. CARDIOMYOPATHY

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: P14419

29d. Date signed (Month, Day, Year): FEBRUARY 18 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. ALTAHA MD GOOD-SAMARITAN-HOSPITAL 5601 LOCH RAVEN BLVD BALTIMORE, MD 21239

State Registrar

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No.

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Charles Paris

2. Date of Death Month: February Day: 14 Year: 2001

3. Time of Death: 04:48pm.

4a Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

**Funeral Director**

5. Social Security Number: 227-36-6348

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 18, 1931

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4404 Apt. G Fells Bridge Drive

10f. Zip Code: 21211

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Schumacher & Seiler Inc. -Trucking

17. Father's Name *(First, Middle, Last)*: Unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Lawrence Benton -Brother in Law

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1201 W. Lake Ave., Baltimore, MD 21210

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore/Wash. Crematory

Date: 2/18/01

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Stephanie Alli

22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home, 2134 Willow Spring Rd. Balt. MD 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Large middle cerebral artery stroke — 4 days.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

non QwAVe Myocardial infarction.

atrial fibrillation.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Onaje A. M.D.

29c. License number: AT 243946.

29d. Date signed *(Month, Day, Year)*: February 14, 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Onaje Greene, Union Memorial Hospital, Baltimore Maryland.

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No 2001 04888

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: M.C. Dolores Pflaum
2. Date of Death — Month: Feb. Day: 14 Year: 2001
3. Time of Death: 9:55 AM
4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212-03-8075
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 27, 1916
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1226 Brewster Street
10f. Zip Code: 21227
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress
16b. Kind of Business/Industry: Restuarant

17. Father's Name *(First, Middle, Last)*: Julius T. Small
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna M. Barber

19a. Informant's Name/Relationship *(Type, Print)*: Richard L. Pflaum/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 404 Newburg Avenue Baltimore, Maryland 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crest Lawn Memorial Gardens — Date: 2/17/01
20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: Juanita R Thomas
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Aspiration pneumonitis | 36 hrs |
| Due to (or as a consequence of): b. | Intracranial hemorrhage | 4days |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Trauma due to fall | 5days |
| Due to (or as a consequence of): d. | Syncope | 5days |

CERTIFICATION APPROVED BY MEDICAL EXAMINER

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Acute renal failure; Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: Feb 9 2001
28b. Time of Injury: Unknown
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Fall
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Home
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 1226 Brewster Street, Baltimore, MD

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: George Hoke M.D.
29c. License number: D53249
29d. Date signed *(Month, Day, Year)*: Feb 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George Hoke MD. St. Agnes Hospital, 900 S. Caton Ave. Baltimore, Maryland 21229

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001
32. Registrar's Signature: G. Spacht

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Dolores Pflaum

10

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Amended Item#30 perDVRG792 2/20/2001 EW

# Certificate of Death

Reg. No. 2001 04889

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| CECILIA | FRANCES | PRUCHA | February 14 2001 | 12:40 am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Stella Maris | Timonium | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-07-5140 | 1☐ M 2☒ F | 91 Yrs. | | | June 4, 1909 | Md. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | Baltimore | Timonium | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 8 Stapleton Ct. #202 | 21093 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 8 | | Home Maker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Charles Hromadka | Anna Vyskocil |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Mary Rachinskas/daughter | 8 Stapleton Ct. #202 Timonium, Md. 21093 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Most Holy Redeemer | 2/19/01 | Baltimore, Md. |

| 21. Signature of Funeral Service Licensee | 22. Name end Address of Facility |
|---|---|
| [signature] | Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset end Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in death) | a. Cerebrovascular Disease | years. |
| Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequenca of): b. | |
| | Due to (or as a consequenca of): c. | |
| | Due to (or as a consequence of): d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Seizure disorder

Arteriosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an eutopsy performed? | 24b. Were eutopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Wes case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, end due to the cause(s) and manner stated.

| 29b. Signature end Title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| [signature] MD | 31554 | 2.14.01 |

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Eddie Nakhuda Stella Maris Hospital Timonium ,Md

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signeture |
|---|---|
| FEB 20 2001 | [signature] |

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: PRUCHA, CECILIA

6

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04890

PIANOWSKI, JENNIE

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Jennie Pianowski
2. Date of Death — Month: February Day: 14th Year: 2001
3. Time of Death: 9:50 PM
4a. Facility Name (If not institution, give street and number): Manor Care Ruxton
4b. City, Town, or Location of Death: Ruxton
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 219-01-0379
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 18, 1915
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Sparks
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 14217 Quail Creek Way # 103
10f. Zip Code: 21152
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 6 Years — College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Peter Gutowski
18. Mother's Name (First, Middle, Maiden Surname): Josephine Doliwa

19a. Informant's Name/Relationship (Type, Print): Stanley Pianowski (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14217 Quail Creek Way #103 Sparks, Maryland 21152

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Holy Rosary Cemetery — Date: 2/17/2001
20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Stephanie Massey
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE — Hours

Due to (or as a consequence of):
b. ASPIRATION PNEUMONIA — Hours to Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. PACREATIC MASS WITH METASTASIS — Years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
MALNUTRITION, DEMENTIA, HYPOTHYROIDISM, PARKINSONS DISEASE.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) — 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Ranganayan
29c. License number: D54288
29d. Date signed (Month, Day, Year): February 15th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMASWAMY L RANGARAJAN, 7445 FURNACE BRANCH ROAD GLEN BURNIE MD 21060

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: Geneva G Sparks

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

01-0828-510
B.K.S TYRONE PUGH
UNKNOWN 01-33

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 04891

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| Tyrone Pugh | FEB. 13, 2001 | 2338 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| UNIVERSITY HOSPITAL | BALTIMORE | |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-76-4395 | 1☒ M 2☐ F | 38 Yrs. | | | 07/08/1962 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | | Baltimore | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 2525 Eutaw Place # 608 | 21217 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Laborer | Construction |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Jessie Davis Pugh | Sally Mae Washington |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jerrilene Pugh / Sister | 1124 St. Agnes Ln., Baltimore, Maryland 21207 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, cremetory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify) | Mt. Zion Cemetery | 02/20/01 | Landsdowne, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Derrick C. Jones | Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in death) | a. GUNSHOT WOUND OF CHEST | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. Due to (or as a consequence of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Dey Year |
|---|---|---|
| 1☐ Yes 2☐ No 9☐ Unknown | 1☐ Live birth 2☐ Felal death 3☐ Ectopic pregnancy 4☐ Pregnent el time of death 5☐ Other (specify) _____ 9☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the ceuse of deeth? | 24e. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown | 1☒ Yes 2☐ No | 1☒ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☒ Yes 2☐ No | Hospital: 1☐ Inpatient 2☒ ER/Oulpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Menner of Death | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined | 2/13/01 | 2235 M | 1☐ Yes 2☒ No | SUBJECT WAS SHOT |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| SIDEWALK OF STREET | 2200 N. FULTON AVE BALTIMORE, MD. |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dale and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dale and place, and due to the cause(s) end manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Yeer) |
|---|---|---|
| M.D. | O.C.M.E | FEB. 14, 2001 |

30. Nema end addrass of person who completed cause of death (Item 23a) (Type, Print)
MARK G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | Jenna D Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04892

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Richard I. Robinson

2. Date of Death (Month, Day, Year): February 16, 2001

3. Time of Death: 05:30 AM

4a. Facility Name *(If not institution, give street and number)*: Gilchrist Hospice Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 195-12-1084

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 1, 1925

9. Birthplace *(State or Foreign Country)*: Maryland

Usuet Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8918 Wilton Avenue

10f. Zip Code: 21043

10g. Citizen of Whet Country?: United States

11. Meritel Status: 1 [ ] Never Merried 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: WW II

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12th Grade | College (1-4or 5+): 4 Years

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Executive

16b. Kind of Business/Industry: Social Security Administration

17. Father's Neme *(First, Middle, Last)*: George W. Robinson

18. Mother's Neme *(First, Middle, Maiden Surname)*: Marie A. Santry

19a. Informent's Name/Reletionship *(Type, Print)*: Betty Robinson - Wife

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 8918 Wilton Avenue; Ellicott City, MD 21043

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: New Cathedral Cemetery | Dete: 2/19/01

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: Joseph Kellner M00333 — Joseph Kellner

22. Name and Address of Facility: Loring Byers Funeral Directors Inc. 8728 Liberty Road; Randallstown, MD 21133

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert tailure. List only one cause on eech line.

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. end-stage renal disease — Approximete Interval Between Onset end Death: months

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest

b. Hypertension — years

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: diabetes mellitus; coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Hospice

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. 2 [ ] **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: H. Anthony Riley, MD

29c. License number: D25205

29d. Dete signed *(Month, Dey, Year)*: February 16, 2001

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Dr. W. Anthony Riley - 6701 North Charles Street; Baltimore, MD 21204

**State Registrar**

31. Dete filed *(Month, Dey, Year)*: FEB 2 0 2001

32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04893

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Delores E. Richards

2. Date of Death Month Day Year: February 14, 2001

3. Time of Death: 23:10 PM

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 579-70-0335

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 8, 1941

9. Birthplace *(State or Foreign Country)*: WashingtonDC

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 853 Powers Street

10f. Zip Coda: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 8 | Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Nama *(First, Middle, Last)*: Edward Richards

18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Ruby Frye

19a. Informant's Name/Ralationship *(Type, Print)*: Helen Colman Daughter

19b. Mailing Addrass *(Street and Number or Rural Route Numbar, City or Town, Stata, Zip Coda)*: 853 Powers Street, Baltimore, Maryland 21211

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Dulaney Valley Memorial | Data: 2/19

20c. Locetion - City or Town, Stata: Cockeysville, MD 21211

21. Signature of Funeral Service Licensee: Tracy Hines Carpenter

22. Name and Address of Facility: Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Maryland

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or hear failura. List only one cause on aach line.

| | | Approximata Intarval Batwaen Onsat and Death |
|---|---|---|
| Immediate Ceuse (Final disease or condition rasulting in daath) a. | Cardiogenic Shock and arrest | Two hours |
| Dua to (or as a consequence of): b. | Massive MI | One day |
| Sequentially list conditions, if any, laading to immediata ceusa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last — Dua to (or as a consequanca of): c. | Corinary Artery Disease | unknown |
| Dua to (or as a consequanca of): d. | | |

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying ceusa givan in Part t.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of ceuse of death? 1☐ Yas 2☒ No

25. Wes casa rafarred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Rasidence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)* | 28b. Tima of Injury | 28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to tha cause(s) and mannar statad.

29b. Signatura and titla of certifiar: Chun Hong, MD.

29c. Licansa number: AT 2438946

29d. Data signad *(Month, Day, Year)*: February 14, 2001

30. Name and addrass of person who completed cause of death (Itam 23a) (Type, Print): Chun Hong MD. Union Memorial Hospital, Baltimore MD 21218

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No: 2001 04894

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Margaret Helen Rovinski
2. Date of Death — Month: FEB Day: 11 Year: 2001
3. Time of Death: 0830
4a. Facility Name *(If not institution, give street and number)*: 1506 Dulaney Valley Road
4b. City, Town, or Location of Death: Baltimore County
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 189 05 1089
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: October 21 1917
9. Birthplace *(State or Foreign Country)*: Swoyersville, PA.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1506 Dulaney Valley Road
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Housekeeping-Own Home

17. Father's Name *(First, Middle, Last)*: Stephen Andrew Ollock
18. Mother's Name *(First, Middle, Maiden Surname)*: Susan Krakovsky

19a. Informant's Name/Relationship *(Type, Print)*: Daria M Rovinski
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1506 Dulaney Valley Road Baltimore, Maryland 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St Stanislaus Ch. Cem. — Date: February 16 2001
20c. Location - City or Town, State: Castle Hayne, North Carolina

21. Signature of Funeral Service Licensee: ▶ Heather Lassahn Chopacki
22. Name and Address of Facility: Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CORONARY ARTERY DISEASE — 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ John G. Lavin MD
29c. License number: D0020795
29d. Date signed *(Month, Day, Year)*: FEB 12, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN G. LAVIN MD 515 FAIRMOUNT AVE TOWSON MD 21286

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001
32. Registrar's Signature: ▶ Penny A Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0924-510
MILTON RICE
ASP

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar AMENDED ITEMS# 23a,b,ptII,27,&28a- per ME 2/21/2001 SS

Reg. No.: 2001 04895

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Milton V. Rice
2. Date of Death: Month FEBRUARY Day 17 Year 2001
3. Time of Death: 12:31 PM
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212-70-6271
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 43 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 26, 1957
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2421 Edmondson Ave.
10f. Zip Code: 21223
10g. Citizan of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:
14. Raca - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Mail Processor
16b. Kind of Business/Industry: Post Office

17. Fathar's Nama (First, Middle, Last): Cleveland A. Rice Sr.
18. Mothar's Name (First, Middle, Maidan Surname): Sallie M. Graham

19a. Informant's Name/Relationship (Type, Print): Mr. Cleveland A. Rice Sr. (Father)
19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code): 2421 Edmondson Ave. Balto. Md. 21223

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or other placa): Garrison Forest
Data: 2/23/2001
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Servica Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batwaan Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. OCCLUSIVE PULMONARY THROMBOEMBOLI
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. DEEP VEIN THROMBOSIS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yas 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at tima of daath 5 [ ] Othar (specify) 9 [ ] Unknown
23d. Date of delivary Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.
NARCOTIC INTOXICATION; COCAINE USE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Wara autopsy findings availabla prior to completion of cause of death? 1 [X] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Othar: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined
28a. Data of Injury (Month, Day Yaar): 2-17-01
28b. Time of Injury: 11:30 A M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: unknown
28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify): home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2431 Edmonson Ave., Balto., MD

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one) 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On tha basis of examination and/or investigation, in my opinion, daath occurrad at tha time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: A. Pittaro, M.D.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): FEBRUARY 18, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Brenda B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 6054.

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04896

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JAMES E ROBINSON
2. Data of Death Month: FEB Day: 16 Yaer: 2001
3. Time of Deeth: 3:30 PM
4a Facility Nama (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Daath: COLUMBIA
4c. County of Death: HOWARD

**Funeral Director**

5. Social Security Number: 212-28-0536
6. Sex: 1 [X] M 2 [ ] F
7. Aga (In yrs. last birthday): 67 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): 03-19-1933
9. Birthpleca (Stata or Foreign Country): SC

Usual Rasidance of Decedant

10a. State: MD
10b. County: HOWARD
10c. City, Town or Location: COLUMBIA
10d. Insida City Limits: 1 [ ] Yas 2 [X] No
10e. Street end Number: 9331 AFTERNOON LANE
10f. Zip Coda: 21045
10g. Citizan of What Country?: USA

11. Maritel Stetus: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Ever in U.S. Armad Forcas? 1 [ ] Yas 2 [ ] No If Yes, Give Yaar or Detas:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - Amaricen Indian, Black, Whita, atc. Specify: BLACK

15. Decedent's Eaucetion (Specify only highest grade complatad)
Elamentary/Secondary (0-12): 12
Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): MANAGEMENT
16b. Kind of Business/Industry: WAREHOUSING

17. Father's Nama (First, Middla, Last): EARLIE ROBINSON
18. Mothar's Nama (First, Middle, Maiden Surnama): RENA MAE DIXON

19a. Informant's Name/Ralationship (Type, Print): DOROTHY ROBINSON, WIFE
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 9331 AFTERNOON LN, COLUMBIA, MD 21045

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar placa): METRO CREMATORY
Dete: 2-20-01
20c. Location - City or Town, Stata: BALTIMORE

21. Signature of Funeral Service Licensee: ▶ Willie E Howell Jr
22. Name end Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 26a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

23e. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failura. List only ona causa on aach lina.

Approximete Intarval Batwaan Onset end Daath

Immediate Ceuse (Final disease or condition resulting in daath)
a. PNEUMONIA — DAYS
Due to (or es e consequence of):
b. METASTATIC BRONCHOGENIC CANCER — WEEKS
Sequentially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Disease or injury thet initieted avants resulting in daath) Last
Dua to (or as a consaquance of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other eignificant conditione** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of deeth? 1 [ ] Yee 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Wes an eutopsy parformad? 1 [ ] Yas 2 [✓] No
24b. Wara autopsy findings evsilabla prior to completion of causa of daath? 1 [ ] Yas 2 [ ] No

25. Was cesa rafarred to medical exeminer? 1 [ ] Yas 2 [✓] No
26. Placa of Death (Chack only ona): Hospital: 1 [✓] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending invastigation 6 [ ] Could not be datarmined
28e. Data of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Streat and Number or Rural Routa Numbar, City or Town, Stata)

29a. Cartifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowladge, death occurred et tha time, date and plece, end due to tha causa(s) and mannar es stated. 2 [ ] **Medical Examiner:** On tha basis of exemination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, end due to tha causa(s) end manner stetad.

29b. Signatura end title of certifier: ▶ [signature] MD
29c. Licansa number: 042892
29d. Data signed (Month, Dey, Year): FEB 16 2001

30. Nama and eddrass of person who completed cause of daath (Item 23a) (Type, Print): FRANCIS CHUDIAN 10724 LITTLE PATUXENT PKWY COLUMBIA MD 21044

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**State Registrar**

31. Data filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04897

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Walter Marcellus Raynor

2. Date of Death (Month, Day, Year): February 15, 2001

3. Time of Death: 6:05 AM

4a. Facility Name (If not institution, give street and number): Future Care, Canton

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212-26-5506

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08/27/1929

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 707 S. Conkin Street

10f. Zip Code: 21224

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 9; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Paper Hanger

16b. Kind of Business/Industry: Home Improvement

17. Father's Name (First, Middle, Last): Norman J. Raynor

18. Mother's Name (First, Middle, Maiden Surname): Marie E. Brune

19a. Informent's Name/Relationship (Type, Print): David Raynor/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 707 S. Conklin St. Baltimore, MD. 21224

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cematary, crematory or othar piece): Metro Crematory

Date: 02/17/01

20c. Location - City or Town, State: Catonsville, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name end Addrass of Facility: Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel disaese or condition resulting in deeth)

a. CEREBROVASCULAR DISEASE

Due to (or as e consequence of):

b. HYPERTENSION

Sequentielly list conditions, if any, leeding to immedieta cause. Enter Underlying Ceuse (Disease or injury thet Initieted events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yee 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [✓] No

25. Was casa referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and menner as stated. 2 [ ] **Medicat Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signatura and title of certifier: [signature] MD

29c. License number: 047945

29d. Date signed (Month, Dey, Year): Feb 16 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Typa, Print): HARIS ACEEM 9101 FRANKLIN SQUARE DRIVE BALTIMORE MA 21237

**State Registrar**

31. Deta filed (Month, Dey, Year): FEB 20 2001

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Walter Raynor 6:05 A.M T.O.D. 2-15-00

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04898

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Emma Elizabeth Royston

2. Date of Death Month / Day / Year: February 14 2001

3. Time of Death: 9:15 AM

4a. Facility Name *(If not institution, give street and number)*: Good Samaritan Nursing Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 365-14-9637

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 2, 1918

9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6401 Loch Raven Blvd. #731

10f. Zip Code: 21239

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Public Library

17. Father's Name *(First, Middle, Last)*: Herman J. Metzger

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma J. Reinhardt

19a. Informant's Name/Relationship *(Type, Print)*: Clarence R. Royston (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6401 Loch Raven Blvd. #731 Baltimore, MD 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Abraham's Church Cemetery

Date: 2/17/01

20c. Location - City or Town, State: Beckleysville, MD

21. Signature of Funeral Service Licensee: ▶ Steven T. Bittle

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction — a few minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jeffrey Cool MD

29c. License number: D0034650

29d. Date signed *(Month, Day, Year)*: February 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey A. Cool, M.D. 5601 Loch Raven Blvd. Baltimore, MD 21239

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 04899

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| MARY | ELIZABETH | RICE | February 14, 2001 | 10:15 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Dulaney Towson Nursing Center | Towson | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 134-03-0054 | 1☐M 2☒F | 90 Yrs. | | | Nov. 21, 1910 | N.Y. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Md. | N/A | Baltimore | 1☒Yes 2☐No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5311 St. Albans Way | 21212 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Home Maker | Own Home |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| George Jerrett | Margaret Renwick |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Donna R. Brown/daughter | 5311 St. Albans Way Baltimore, Md. 21212 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Dulaney Valley Memorial Gardens | Feb. 17, 01 | Timonium, Md. |

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Myocardial Infarction | 2 hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequance of): | |
| | d. Due to (or as a consequance of): | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | Month Day Year |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23a. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☒No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ [signature] Attending MD | 037016 | February 15, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kenneth M. Green, MD 6701 N. Charles St, Suite 410S Baltimore, MD 21204

**State Registrar**

31. Date filed (Month, Day, Year) FEB 20 2001

32. Registrar's Signature ▶ [signature] G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04900

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MANIBEN S. RAWAL
2. Date of Death: Month February Day 14 Year 2001
3. Time of Death: 7:15 AM
4a. Facility Name (If not institution, give street and number): Manor Care Ruxton
4b. City, Town, or Location of Death: Ruxton
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-76-7955
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 13, 1913
9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Lutherville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11216 Five Springs Rd.
10f. Zip Code: 21093
10g. Citizen of What Country? India

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home maker
16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): Govindram vyas
18. Mother's Name (First, Middle, Maiden Surname): Jamlaben Unknown

19a. Informant's Name/Relationship (Type, Print): Mr. Dinker Rawal/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11216 Five Springs Rd. Lutherville, Md. 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Hilltop Service Corp.
Date: 2/17/01
20c. Location - City or Town, State: Towson, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Stroke — Months

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D-12849
29d. Date signed (Month, Day, Year): 2-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.H. GHILADI. MD. 7600 OSLER Dr. TOWSON MD. 21204

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: [signature]

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**To be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04901

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Sadie Rubin
2. Date of Death (Month, Day, Year): February 18 2001
3. Time of Death: 1am
4a. Facility Name (If not institution, give street and number): North West Hospital
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore County

**Funeral Director**

5. Social Security Number: 216-03-3209
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 19,1909
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3800 OLD COURT ROAD
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATOR
16b. Kind of Business/Industry: CITY GOVERNMENT

17. Fether's Name (First, Middle, Last): JOSEPH KLEIN
18. Mother's Name (First, Middle, Maiden Sumame): MARY SCHWARTZ

19a. Informant's Name/Reletionship (Type, Print): PHILIP KLEIN / NEPHEW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3209 HUNTING TWEED DRIVE - OWINGS MILLS, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): ACHIM AHAVAS SHALOM AGUDAS
Date: 2/19/01
20c. Location - City or Town, State: ROSEDALE, MD

21. Signature of Funeral Service Licensee: Robert Thomas
22. Name end Address of Fecility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): e. Cerebero-vascular accident — one week

Due to (or as a consequence of): b. Atherosclerosis — years

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

Due to (or es a consequence of): c.

Due to (or es a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and manner steted.

29b. Signeture end title of certifier: Ayman MD
29c. License numbar: D46263
29d. Date signed (Month, Dey, Year): Febuary 18 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. Youssri, Ayman. Northwest Hosp. Balto, Md.

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Benjamin B. Sowell

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04902

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: DOROTHY · D. REINMUTH

2. Data of Death Month / Day / Year: FEBUARY / 16, 2001

3. Time of Death: 11:31 AM

4a Facility Name *(If not institution, give street and number)*: GILLCREST HOSPICE CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 216-18-4741

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: JAN 13, 1922

9. Birthplaca *(State or Foreign Country)*: MD

Usual Rasidance of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: OVERLEA

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 5803 WESTWOOD AVE

10f. Zip Coda: 21206

10g. Citizan of What Country?: U.S.A

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedant's Education *(Specify only highest grade compiatad)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: HOME.

17. Fathar's Nama *(First, Middle, Last)*: GEORGE. H. ROBINSON

18. Mothar's Nama *(First, Middla, Maidan Surname)*: ELLA STINCHCOMB

19a. Informant's Name/Ralationship *(Type, Print)*: ELAINE. R. KALB

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 5803 WESTWOOD AVE, BALTO. MD. 21206

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetery, cramatory or other place)*: CEDAR HILL CEMETERY

Date: 2/19/01

20c. Location - City or Town, State: GLEN BURNIE, MD

21. Signature of Funeral Service Licensaa: ▶ Paul M. Stella

22. Nama and Address of Facility: HARTLEY MILLER FUNERAL HOME CHTD. 7527 HARFORD RD, BALTO. MD. 21234

**Physician /Medical Examiner**

23a. Part1. Enter the diseasa, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each line.

Approximata Interval Batween Onsat and Death

Immediate Causa (Final disease or condition resulting in death): a. Gastric cancer — months

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaasa or Injury that initiated events resulting in death) Last:

b. Dua to (or as a consequence of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings availabla prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was cesa rafarred to medical axaminar? 1☐ Yes 2☒ No

26. Place of Death *(Chack only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, data and place, and due to tha cause(s) and mannar stated.

29b. Signature and tita of certifiar: ▶ Helen M Gordon MD

29c. License number: 90 51926

29d. Data signed *(Month, Day, Year)*: Feb 16, 2001

30. Nama and address of person who complatad causa of daath (Item 23a) (Type, Print): Helen M Gordon MD 6565 N. Charles St, Baltimore MD 21204

**State Registrar**

31. Data filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signatura: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04903

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Toni Kay Streett

2. Date of Death Month: FEB Day: 18, Year: 2001

3. Time of Death: 4:15am

4a. Facility Name *(If not institution, give street and number)*: 3307 Offutt Road

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-38-7387

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: APR 11, 1940

9. Birthplace *(State or Foraign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3307 Offutt Road

10f. Zip Code: 21133

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name *(First, Middle, Last)*: Unk. Wilson

18. Mothar's Name *(First, Middle, Maiden Sumema)*: Lorraine Ward

19a. Informant's Neme/Relationship *(Type, Print)*: William W. Streett/husband

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 3307 Offutt Road Randallstown, MD 21133

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Placa of Disposition *(Neme of cemetery, cremetory or other piece)*: Metro Crematory, Inc.

Date: 2/19/01

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funtral Service Licensee: Dawn F. McDonald

22. Nama and Addrass of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth)

a. END STAGE EMPHYSEMA — >20yrs

Due to (or es e consequence of):

b. CONGESTIVE HEART FAILURE — >10yrs

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to complation of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 8☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and placa, end due to the ceuse(s) and manner steted.

29b. Signature end title of certifier: ATTENDING

29c. License number: D 40390

29d. Date signed *(Month, Dey, Year)*: FEBRUARY 19, 2001

30. Neme and address of parson who completed cause of death (Item 23a) (Type, Print): P.R. DESAI, MD; 23 CROSSROADS DRIVE, #325, OWINGS MILLS, MD 21117

**State Registrar**

31. Date filed *(Month, Dey, Year)*: FEB 20 2001

32. Registrer's Signature: Donna G Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04904

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): HELEN DAVIS SWINSON
2. Date of Death (Month, Day, Year): February 13, 2001
3. Time of Death: 1:25 am
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 219-14-0143
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 12, 1917
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1067 ELLICOTT DRIVE
10f. Zip Code: 21223
10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 TH GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SOCIAL SECURITY CLERK
16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Father's Name (First, Middle, Last): LEE DAVIS JR.
18. Mother's Name (First, Middle, Maiden Surname): AMANDA BENSON

19a. Informant's Name/Relationship (Type, Print): CHARLES CODE (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2413 SHIRLEY AVENUE, BALTIMORE, MD 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): ARBUTUS CEMETERY | Date: 02-16-01
20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee: Brown
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

| | | Approximate Interval Between Onset end Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Aspiration pneumonia | hours |
| Due to (or as a consequence of): b. | Sepsis | days |
| Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Cardiac Arrhythmia | days |
| Due to (or as a consequence of): d. | Diabetes Mellitus | years |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Normal pressure Hydrocephalus; Hypethyrodism

23b. Did tobacco uaa contributa to the causa of death? 1☐ Yss 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and pleca, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the besis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: S. Yousif, M.D.
29c. License number: 13133
29d. Date signed (Month, Dey, Year): February 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SOHAIR YOUSIF 900 Caton Ave Baltimore, MD 21229

**State Registrar**

31. Date filed (Month, Dey, Year): FEB 2 0 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

SWINSON, HELEN

5

**Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04905

**Physician /Medical Examiner**

1. Decedent's Nama (First, Middla, Last): JOHN STACK

2. Deta of Daath — Month: FEBRUARY Day: 10 Yaar: 2001

3. Time of Deeth: 6:05 AM

4e Facility Neme (If not institution, giva street and number): NORTHWEST HOSPITAL

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212-18-7162

6. Sex: 1 ☒ M 2 ☐ F

7. Aga (In yrs. last birthday): 75 Yrs. — If Under 1 Yaer: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 11-9-1925

9. Birthplaca (State or Foraign Country): unk

Usual Residence of Decedent

10a. Stata: MD

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1 ☐ Yas 2 ☒ No

10e. Street and Number: 10518 Marriottsville Road

10f. Zip Coda: 21133

10g. Citizan of What Country?: USA

11. Meritel Status: unk
1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Dacadant Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☐ No: unk
If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - Amarican Indian, Black, Whita, atc.
Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elamantary/Secondary (0-12): unk
College (1-4or 5+): unk

16a. Decadant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use ratired): unk

16b. Kind of Businass/Industry: unk

17. Fathar's Nama (First, Middla, Last): unk

18. Mother's Nama (First, Middla, Maidan Surnama): unk

19a. Informant's Name/Relationship (Type, Print): Northwest Hospital

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda): 5401 Old Court Road Randallstown, MD 21133

20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata
4 ☐ Donation 5 ☒ Othar (Specify): in state

20b. Place of Disposition (Nama of cematary, cramatory or other place)

Deta

20c. Location - City or Town, Stata

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name end Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part1. Enter the disease, of complications thet causad tha death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach line.

Approximata Interval Between Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death)
a. METASTATIC BLADDER CANCER

Dua to (or as a consequance of):

Sequentially list conditions, if eny, laeding to immedieta cause. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in death) Last
b.

Dua to (or as a consequance of):

c.

Due to (or es e consaquenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?
1 ☐ Yas 2 ☒ No

24b. Wara autopsy findings availabla prior to compiation of causa of death?
1 ☐ Yas 2 ☒ No

25. Wes casa rafarred to medical examinar?
1 ☐ Yas 2 ☒ No

26. Placa of Death (Check only ona)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify)

27. Mannar of Death
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicida 5 ☐ Panding investigetion 6 ☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Specify)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, data and place, and dua to the causa(s) and mannar as stated.
2 ☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: MD

29c. Licansa number: D54352

29d. Data signad (Month, Dey, Year): FEBRUARY, 10, 2001

30. Neme end eddress of person who complated cause of deeth (Item 23a) (Type, Print): MIRCEA TODOR
NORTHWEST HOSPITAL, 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133

**State Registrar**

31. Data filed (Month, Day, Year): FEB 2 0 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-0855-510
mnmr
Tulley Sullivan

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04906

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| Tully | C. | Sullivan | February 14, 2001 | 1653 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 3600 blk. of Frankford Avenue | Baltimore | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-11-8388 | XX 1 M 2 F | 15 Yrs. | | | 11 25 85 | M D. |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | NA | Baltimore | 1 X Yes 2 No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 5908 Darien Ct | 21206 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 X Never Married 2 Married 3 Widowed 4 Divorced | 1 Yes 2 X No If Yes, Give Year or Dates: | 1 Yes 2 X No Specify: | Specify: Black |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 10th grade | na | na | na |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Tully Keith Sullivan | Karen Kelley |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Karen Sullivan-Mother | 5908 Darien Ct., Baltimore Md 21206 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | New Cathedral Ceme | 2/19/01 | Baltimore, Md |

21. Signature of Funeral Service Licensee: Glynis B Kuke

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnent at time of death 5 Other (specify) 9 Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

| 23e. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 Yes 2 X No 3 Probably 4 Unknown | 1 X Yes 2 No | 1 X Yes 2 No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 XX Other (Specify) at scene |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 Natural 2 X Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | 2/14/01 | 1635 M | 1 Yes 2 X No | Passenger in auto accident |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| STREET | 3600 Blk Frankford Ave |

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| | O.C.M.E. | February 15, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Aaron Locke, MD, 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 2 0 2001 | Geneva G Addis |

DHMH 17 Rev 1/2001

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification; To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04907

Stratman, George

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): George MERVIN STRATMANN
2. Data of Death: Month February Day 17 Year 2001
3. Time of Death: 8:08 am
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 217-24-5613
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Dec 23, 1928
9. Birthplace (State or Foreign Country): MD.

Usual Residance of Decedant

10a. State: MD.
10b. County: BALTIMORE
10c. City, Town or Location: DUNDALK
10d. Insida City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 6827 HOLABIRD AVE
10f. Zip Coda: 21222
10g. Citizan of What Country?: U.S.A.
11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Ever in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:
14. Raca - Amarican Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): Collega (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): METALURGIST
16b. Kind of Businass/Industry: STEEL
17. Fathar's Nama (First, Middla, Last): GEORGE HERMAN STRATMANN
18. Mothar's Nama (First, Middla, Maidan Sumame): LAURA WENIG
19a. Informant's Name/Ralationship (Type, Print): VIRGIE STRATMANN - WIFE
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 6827 HOLABIRD AVE. BALTO MD 21222
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): OAK LAWN
Data: 2/21/01
20c. Location - City or Town, Stata: BALTO. MD.
21. Signature of Funaral Sarvice Licensee: Anthony C. Connelly
22. Nama and Addrass of Facility: Connelly Funeral Home of Dundalk, PA. 7110 Sollers Pt. Rd Balto. MD 21222

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0036**

**Physician /Medical Examiner**

23a. Part I. Entar tha disaasa, or complications that caused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Causa (Final diseasa or condition resulting in death)
a. Respiratory failure — 10 minutes
Dua to (or as a consequanca of):
b. Aspiration pneumonia
Dua to (or as a consequanca of):
Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disaasa or injury that initiated evants resulting in death) Last
c. Methicillin resistant staph averf bacteremia
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings availabla prior to complation of causa of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical axaminar? 1 [ ] Yas 2 [X] No
26. Placa of Death (Check only ona): Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Othar: 4 [ ] Nursing Homa 5 [ ] Rasidanca 6 [ ] Othar (Specify)
27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Division of Vital Records, P.O. Box 68760,**

29a. Certifiar (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar stated.
29b. Signatura and Title of certifiar
29c. Licansa number: P 22576
29d. Data signed (Month, Day, Year): February 17, 2001
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Kauser F. Khan, 9000 Franklin Square Drive, Baltimore, Maryland 21237

**State Registrar**

31. Data filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signatura

DHMH 16 Rev 6/95

ORIGINAL

01-0705-005
CJ
Lana Gale Saunders

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED# 23,ptII&27 per ME G793 03/30/01 SS

# Certificate of Death

Reg. No. 2001 04908

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lana G. Saunders

2. Date of Death: Month February Day 07 Year 2001

3. Time of Death: 02:40 P.M

4a. Facility Name (If not institution, give street and number): 770 Maple Crest Drive

4b. City, Town, or Location of Death: Middle River

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 233-88-1646

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 14, 1952

9. Birthplace (State or Foreign Country): WV

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore Maryland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 770 Maple Crest Drive

10f. Zip Code: 21220

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Line Worker

18b. Kind of Business/Industry: Automotive

17. Father's Name (First, Middle, Last): Ralph Saunders

18. Mother's Name (First, Middle, Meiden Surneme): Lorraine Moore

19e. Informent's Name/Relationship (Type, Print): Tammy Matthews / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26342 Dale Court, Roseville, MI 48066

20a. Method of Disposition: 1☐ Buriel 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Michigan Memorial Park, Date: Feb. 15, 2001

20c. Location - City or Town, State: Flat Rock, MI

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

Sequentialty list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) N/A 9☐ Unknown

23d. Date of delivery Month Day Year: N/A

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: BIPOLAR DISORDER

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Scene

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☒ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Dennis J Chute MD

29c. License number: O.C.M.E.

29d. Dete signed (Month, Day, Year): February 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04909

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Annie Sawyer

2. Date of Death: Month 2 Day 15 Year 01

3. Time of Death: 1:30 AM

4e. Facility Name (If not institution, give street and number): MARINA HEALTH OF CATONSVILLE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: CATONSVILLE

**Funeral Director**

5. Social Security Number: 213-01-4430

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 98 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-15-02

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10e. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3030 WALBROOK AVE APT #2

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC

16b. Kind of Business/Industry: HOUSEKEEPING

17. Father's Name (First, Middle, Last): JAMES GATLING

18. Mother's Name (First, Middle, Maiden Surname): ANNIE SEANFORD

19a. Informant's Name/Relationship (Type, Print): BRENDA WRIGHT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3713 COLLIER RD, RANDALLSTOWN, MD 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL

Date: 2-19-01

20c. Location - City or Town, State: ARBUTUS MD

21. Signature of Funeral Service Licensee: Willie E Howell Jr.

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO, MD 21207

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia — 7d

Due to (or as a consequence of):

b. atherosclerotic disease — 2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. advanced Dementia — 2 yrs

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: physician

29c. License number: D29769

29d. Date signed (Month, Day, Year): 2/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mauricio D Alburquerque MD 516 N. Rolling Rd Balto Md 21228

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04910

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Kenneth Douglas Shiflett
2. Date of Death (Month, Day, Year): February 14, 2001
3. Time of Death: 12:14 AM
4a. Facility Name *(If not institution, give street and number)*: 99 Kinship Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212-58-1468
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 49 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 15, 1951
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 99 Kinship Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: 1970-72
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 9 Years — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Longshoreman
16b. Kind of Business/Industry: Maryland Port Authority

17. Father's Name *(First, Middle, Last)*: John James Shiflett
18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Mae Brown

19a. Informent's Name/Relationship *(Type, Print)*: Mrs. Cathy E. Shiflett (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 99 Kinship Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sacred Ht. of Jesus Cem.
Date: 2/17/2001
20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Thad M. Duda
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)
a. LIVER CANCER (HEPATOMA) — 3 months
Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.
Liver cirrhosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: Rodrigo B. Erlich M.D.
29c. License number: D54911
29d. Date signed *(Month, Day, Year)*: 02-14-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RODRIGO B. ERLICH - 4940 EASTERN AVE., BALTIMORE MD 21224

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001
32. Registrer's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Howard M. Singer
crn
01-0857-005

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,27,28a-f G794 041701 SS AMENDED ITEMS# 23& 27 per ME G793 050701 SS

# Certificate of Death

Reg. No. 2001 04911

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| HOWARD | M. | SINGER | February 14, 2001 | 10:11 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 200 Rosewood Lane | Owings Mills | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-09-9134 | 1[X] M 2[ ] F | 51 Yrs. | | | JULY 25,1949 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1[ ] Yes 2[X] No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1 STONEHENGE CIRCLE #8 | 21208 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1[X] Never Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced | 1[ ] Yes 2[X] No If Yes, Give Year or Dates: | 1[ ] Yes 2[X] No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| NONE | | NONE | NONE |

| 17. Father's Name (First, Middle, Last) | | 18. Mother's Name (First, Middle, Maiden Surname) | |
|---|---|---|---|
| IRVIN | SINGER | EVELYN | BARBER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| EVELYN SINGER / MOTHER | 1 STONEHENGE CIRCLE #8 - BALTIMORE, MD 21208 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify) | SHAAREI ZION CEMETERY | 2/16/01 | ROSEDALE, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Robert Levinson | SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 |

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA IN ASSOCIATION WITH MENTAL RETARDATION AND SEIZURE DISORDER COMPLICATING THERAPY FOR HIP FRACTURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or es e consequence of):

d. Due to (or as a consequence of):

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown | 23c. If yes, outcome of pregnancy 1[ ] Live birth 2[ ] Fetel death 3[ ] Ectopic pregnency 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown | 23d. Date of delivery Month Day Year |
|---|---|---|

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1[ ] Yes 2[X] No 3[ ] Probebly 4[ ] Unknown

| 24e. Was an autopsy performed? 1[X] Yes 2[ ] No | 24b. Were eutopsy findings available prior to completion of ceuse of death? 1[X] Yes 2[ ] No |
|---|---|

| 25. Was case referred to medical examiner? 1[X] Yes 2[ ] No | 26. Place of Death (Check only one) Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[ ] Residence 8[X] Other (Specify) at scene |
|---|---|

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| ~~1[X] Natural~~ 2[X] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined | 2-1-01 | unknown M | 1[ ] Yes 2[X] No | subject fell |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): hospital

28f. Location (Street and Number or Rural Route Number, City or Town, State): Rosewood Hospital Ctr., Owings Mills, MD

29a. Certifier (Check only one) 1[ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| J. Pestaner, M.D | O.C.M.E. | February 15, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | G. Sparks |

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 04912

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Mildred Straughan | February 14th 2001 | 11:55 pM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Johns Hopkins Bayview Medical Center | Baltimore City | N/A |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 190-16-6928 | 1☐M 2☒F | 76 Yrs. | | | March 21, 1924 | Pennsylvania |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Baltimore | Dundalk | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7608 Meadow Way | 21222 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Rece - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 Years | | Computer Programer | Corrections/Detention |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| John Long | Goldie Baker |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Denzil Long, Sr. (Son) | 7608 Meadow Way Dundalk, Maryland 21222 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Gardens of Faith Cem. | 2/20/2001 | Baltimore, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ [signature] | Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Chronic Obstructive Pulmonary Disease | Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐Yes 2☒No | 1☐Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☐Yes 2☒No | Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Dete signed (Month, Day, Yeer) |
|---|---|---|
| ▶ David Nam DO | AF2664200-U294 | February 14th 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David Nami Johns Hopkins Bayview 4940 Eastern Avenue Baltimore, MD 21224

**State Registrar**

| 31. Date filed (Month, Day, Yeer) | 32. Registrar's Signature |
|---|---|
| FEB 2 0 2001 | ▶ [signature] |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04913

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): PEARL H. SURRATT.

2. Data of Death — Month: February Day: 17 Year: 2001

3. Time of Death: 11:05 PM

4e. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD.

4b. City, Town, or Location of Death: BALTIMORE, MD

4c. County of Death:

**Funeral Director**

5. Social Security Number: 235-10-5870

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): Oct. 3, 1918

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7912 Wise Ave.

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 11 Years — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Garment Company

17. Father's Name (First, Middle, Last): John Henry Holloway

18. Mother's Name (First, Middle, Maiden Surname): Florence Mae Cook

19a. Informant's Name/Relationship (Type, Print): Mr. Millard P. Surratt (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3400 Kings Road South St. Augustine, FL 22086

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Oak Lawn Cemetery — Date: 2/21/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Dani C. Caudo

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. SEPSIS.

Due to (or as a consequence of):
d. MULTI ORGAN FAILURE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

CROHN'S DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ratna Nair PGY2.

29c. License number: P13965

29d. Date signed (Month, Day, Year): FEBRUARY 17 2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RATNA NAIR GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTIMORE. MD.

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: Donna G Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04914

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: EDWIN B. STUBE

2. Date of Death Month: 2 Day: 17 Year: 01

3. Time of Death: 10 AM

4a. Facility Name *(If not institution, give street and number)*: 827 W. CROSS STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

**Funeral Director**

5. Social Security Number: 299-22-8831

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APRIL 29 1922

9. Birthplace *(State or Foreign Country)*: N.J.

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 827 W. CROSS STREET

10f. Zip Code: 21230

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CLERGY

16b. Kind of Business/Industry: CHURCH

17. Father's Name *(First, Middle, Last)*: CHARLES F. STUBE

18. Mother's Name *(First, Middle, Maiden Surname)*: ETHEL BROWNELL

19e. Informent's Name/Relationship *(Type, Print)*: JULIANA RAU

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 303 ORLEY ROAD CATONSVILLE, MD 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. GEORGE'S EPISCOPAL CHURCH

Date: 2/19/2001

20c. Location - City or Town, State: MT. SAVAGE MD.

21. Signature of Funeral Service Licensee: ▶ [signature] LFD.

22. Name and Address of Facility: JOSEPH L. CANBY FUNERAL DIRECTOR 567 DEER HILL ROAD SYKESVILLE, MD. 21784

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular disease — 1995

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus, Type 2

Cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es steted. 2 [ ] **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D0070040

29d. Date signed *(Month, Day, Year)*: 2/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Evans MD 700 Washington Blvd, Balto, MD 21230

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: ▶ [signature] D Sparks

DHMH 16 Rev 6/95

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**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04915

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANNA MARGARET SMITH
2. Date of Death (Month, Day, Year): FEB. 17, 2001
3. Time of Death: 10:40AM
4a. Facility Name (If not institution, give street and number): EASTPOINT NURSING CENTER
4b. City, Town, or Location of Death: BERKSHIRE
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Security Number: 215-14-9931
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 6, 1922
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: BALTIMORE
10c. City, Town or Location: DUNDALK
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6524 ST. HELENA AVE.
10f. Zip Code: 21222
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11TH; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name (First, Middle, Last): WILLIAM RIPPEL
18. Mother's Name (First, Middle, Maiden Surname): MARIE RODEN
19a. Informant's Name/Relationship (Type, Print): JESSIE J. SMITH/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7846 NORTH COVE RD., BALTIMORE, MD. 21219
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): OAK LAWN
Date: 2/19/01
20c. Location - City or Town, State: BALTIMORE, MD.
21. Signature of Funeral Service Licensee: ▶ Richard J. Leasure M005 11
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CONGESTIVE HEART FAILURE — 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES, HYPERTENSION, RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Matthew McNabney
29c. License number: D45757
29d. Date signed (Month, Day, Year): FEB 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW MCNABNEY 5505 HOPKINS BAYVIEW CIRCLE BALT MD 21224

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: ▶ Bernard G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04916

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): JOHN THOMAS TODD JR.
2. Date of Death: Month FEB Day 15 Year 2001
3. Time of Death: 10:50pm
4a. Facility Name (If not institution, give street and number): Riverview Nursing Home
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimroe

**Funeral Director**

5. Social Security Number: 025-16-3147
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 23 1923
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8030 Eastdale Road
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Truck

17. Father's Name (First, Middle, Last): John Thomas Todd SR.
18. Mother's Name (First, Middle, Maiden Surname): Sarah LaPorte

19a. Informant's Name/Relationship (Type, Print): Judith Norman /
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8030 Eastdale Road Baltimore MD 21224

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory Inc
Date: 2/17/01
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace AVe, Baltimore MD 21221

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Airway Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 2/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOOD 201-109 Back River Neck Rd Baltimore MD 21221

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 200a.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No 2001 04917

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): CHARLES THOMPSON
2. Date of Death (Month, Day, Year): FEBRUARY 18, 2001
3. Time of Death: 1236 PM
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-16-0157
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB 19, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Stevenson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1525 Hillside Road
10f. Zip Code: 21153
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Delivery Person
16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Amos Thompson
18. Mother's Name (First, Middle, Maiden Surname): Lulu Peterson

19a. Informant's Name/Relationship (Type, Print): Norma Thompson/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1525 Hillside Road Stevenson, MD 21153

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 2-20-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)
e. SEPSIS
Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CORONARY ARTERY DISEASE
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: Sanjog Pangarkar
29c. License number: AS 2402321-SP9206
29d. Date signed (Month, Dey, Year): FEBRUARY 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SANJOG PANGARKAR, M.D. 2401 WEST BELVEDERE AVENUE, BALTIMORE, MARYLAND

**State Registrar**

31. Dete filed (Month, Dey, Year): FEB 2 0 2001
32. Registrer's Signeture: Barbara G Sparks

ORIGINAL

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No 2001 04918

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Helene Katherine Klein Tomalino

2. Date of Death Month FEB Day 15, Year 2001

3. Time of Death: 4:55pm

4a. Facility Name *(If not institution, give street and number)*: Future Care of Chesapeake

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 713-01-1346

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV 30, 1911

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 715 Benfield Road

10f. Zip Code: 21146

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Office Manager

16b. Kind of Business/Industry: Railroad Supply

17. Father's Name *(First, Middle, Last)*: Peter Klein, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Katherine Kramer

19a. Informant's Name/Relationship *(Type, Print)*: Meredith Morris/niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 1400 Erwin, TN 37650

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Metro Crematory, Inc.

Date: 2/16/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. renal carcinoma — unknown

Due to (or as a consequance of):

b. lung cancer — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

deep vein Thrombosis, diabetes, hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D41955

29d. Date signed *(Month, Day, Year)*: 2-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rebecca Don MD 479 Jumpers Hole Rd #304 Severna Park, MD 21146

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 2 0 2001

32. Registrar's Signature: Serena G Sparks

DHMH 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04919

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): John Jacob Tomalino
2. Data of Death: Month FEB Day 17, Year 2001
3. Time of Death: 4:06am
4a. Facility Nema (If not institution, giva street and number): Future Care of Chesapeake
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 170-24-3966
6. Sex: 1 [X] M 2 [ ] F
7. Aga (In yrs. last birthday): 91 Yrs. | If Under 1 Yaar: Months | Days | If Under 24 Hrs.: Hours | Min.
8. Data of Birth (Month, Day, Year): JULY 16, 1909
9. Birthplace (Stata or Foraign Country): Pennsylvania

Usual Residance of Decedant

10a. Stata: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 71 Milburn Circle
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Maritel Status: 1 [ ] Nevar Married 2 [ ] Married 3 [X] Widowad 4 [ ] Divorced
12. Wes Decedant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [ ] No If Yes, Give Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Raca - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grade compilated): Elamentary/Secondary (0-12): | Collega (1-4or 5+): 4
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Sales
16b. Kind of Businass/Industry: Industrial Soaps/ Detergents

17. Fathar's Nama (First, Middle, Last): Felix Tomalino
18. Mother's Name (First, Middle, Maidan Surnama): Maria Issert

19a. Informant's Name/Relationship (Type, Print): Susan Tomalino Smith/Daughter
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 71 Milburn Circle Pasadena, MD 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Nema of cematary, cramatory or othar placa): Metro Crematory Inc.
Data: 2-19-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funaral Service Licensee: Dawn F. McDonald
Dawn F. McDonald
22. Nama and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

**Physician /Medical Examiner**

23a. Part I. Enter tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach line.

Approximata Intervel Between Onset and Death

Immediate Causa (Final disaasa or condition rasulting in daath)
a. cerebrovascular accident, recurrent — days
Dua to (or as a consequance of):
b. atherosclerotic vascular disease — years

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.
malignant melanoma with multiple intra abdominal masses

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy pertormed? 1 [ ] Yas 2 [X] No
24b. Were autopsy findings availabla prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Wes casa rafarrad to medical examinar? 1 [ ] Yas 2 [X] No
26. Place of Death (Check only ona)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Othar: 4 [X] Nursing Home 5 [ ] Rasidance 6 [ ] Other (Specify)

27. Manner of Daath: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending invastigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurrad
28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledga, daath occurrad at tha time, data and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurrad at tha tima, date and piaca, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifiar
29c. License number: D41955
29d. Data signed (Month, Day, Year): 2-19-01

30. Nama and address of person who compilated causa of daath (Item 23a) (Type, Print): Rebecca Con MD 479 Jumpers Hole Rd Severna Park MD 21146

**State Registrar**

31. Data filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed/filed by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04920

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Zona Taylor

2. Date of Death: Month: February Day: 14 Year: 2001

3. Time of Death: 2 Am

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 091-38-6535

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 17, 1909

9. Birthplace (State or Foreign Country): California

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6336 Cedar Lane

10f. Zip Code: 21044

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): housewife

16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Edward Celestine Owen

18. Mother's Name (First, Middle, Maiden Surname): Sadie Viola Cargile

19a. Informant's Name/Relationship (Type, Print): Marcia Heaton/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10567 Jason Lane Columbia, MD 21044

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D22567

29d. Date signed (Month, Day, Year): February 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary Brock 11055 Little Patuxent Columbia, Maryland 21044

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04921

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Myrtle Victoria Thomas

2. Date of Death (Month, Day, Year): February 17 2001

3. Time of Death: 9:15 AM

4a. Facility Name (If not institution, give street and number): 1803 Larch Drive

4b. City, Town, or Location of Death: Edgewood

4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 216-52-0885

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): April 25 1934

9. Birthplaca (State or Foraign Country): W. Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 1133 Steelton Ave.

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S. of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Suppervisor

16b. Kind of Business/Industry: Sewing Factory

17. Father's Nama (First, Middle, Last): William Henery Lester

18. Mothar's Nama (First, Middla, Maidan Sumama): Sarah Loma Crigger

19a. Informant's Name/Relationship (Type, Print): Vickie Winter ( Daughter )

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 1803 Larch Drive Edgewood, Maryland 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or othar place): Oak Lawn — Data: February 21,2001

20c. Location - City or Town, Stata: Eastpoint, Maryland

21. Signature of Funeral Service Licensee: Mark A. Dabrowski

22. Name and Address of Facility: W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona cause on each line. — Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death): a. Metastatic Gallbladder Cancer — 5 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion ol causa ot death? 1☐ Yas 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Rasidance 6☒ Other (Specify) 1803 Larch Dr. Edgewood Md. 21040

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the tima, data and place, and due to tha cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Janet Cooper MD

29c. License number: D46118

29d. Date signed (Month, Day, Year): February 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Janet Cooper M.D.--1447 York Road Lutherville, Maryland 21093

**State Registrar**

31. Data filed (Month, Day, Year): FEB 2 0 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No 2001 04922

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Norman Howard Tripps
2. Date of Death (Month, Day, Year): FEBRUARY 13, 2001
3. Time of Death: 10.44 A M
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 215-30-7782
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 01, 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3818 Cottage Avenue
10f. Zip Code: 21212
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Blast Furnace Operator
16b. Kind of Business/Industry: Steel

17. Father's Name (First, Middle, Last): James Tripps
18. Mother's Name (First, Middle, Maiden Surname): Edith Williams

19a. Informant's Name/Relationship (Type, Print): Roberta Tripps (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3818 Cottage Avenue Baltimore, Maryland 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park
Date: 2/16/01
20c. Location - City or Town, State: Randallstown, MD.

21. Signature of Funeral Service Licensee: Dennis B. Caple
22. Name and Address of Facility: Dennis B. Caple Funeral Home 4601 York Road Baltimore, Maryland 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART DISEASE

Due to (or as a consequence of):
b. ISCHEMIC HEART DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnency 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHR. OBST. LUNG DIS.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. Braxton II
29c. License number: D00516
29d. Date signed (Month, Day, Year): February 15, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. BRAXTON II 3100 Towanda Ave Balto, Md. 21215

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

CPS
01-0887-005
STEVEN TOMPAKOV

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

ADMEND ITEMS: #10C, F, PER F.H. G793 3-30-01 WR.

1- For State Registrar ADMEND ITEM: #5 PER F.H. G793 3-30-01 WR.

# State of Maryland - Department of Health and Mental Hygiene
## Certificate of Death

Reg. No. 2001 04923

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| STEVEN | | TOMPAKOV | February 15, 2001 | 3:11 PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Northwest Hospital Center | Randallstown | Baltimore |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| ~~212-48-5597~~ 212-48-5596 | 1 X M 2 ☐ F | 53 Yrs. | | | FEB.4,1948 | MD |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | ~~RANDALLSTOWN~~ BALTIMORE | 1 ☐ Yes 2 X No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 4613 HORIZON CIRCLE #203 | ~~21133~~ 21208 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | 1 ☐ Yes 2 X No Specify: | Specify: WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| | 5+ | C.P.A. | ACCOUNTING |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| ALVIN TOMPAKOV | FRIEDA FLEISCHER |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| FRIEDA TOMPAKOV / MOTHER | 192 BRIGHTON E. - BOCA RATON, FL 33434 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | HAR ZION TIFERETH ISRAEL | 2/18/01 | ROSEDALE, MD |

21. Signature of Funeral Service Licensee: Jayne Sol

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Cardiac Arrhythmia | |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Arteriosclerotic Cardiovascular Disease | |
| | Due to (or as a consequence of): | |
| | c. | |
| | Due to (or as a consequence of): | |
| | d. | |

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month Day Year |
|---|---|---|
| 1 ☐ Yes 2 X No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

obesity

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1 ☐ Yes 2 X No | 1 ☐ Yes 2 ☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 X Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Dennis J. Chuteau | OCME | February 16, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis Chuteau 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 20 2001 | D. Sparks |

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04924

ALICE THOMAS

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

| | | | |
|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last): Alice F. Thomas | | 2. Date of Death (Month, Day, Year): FEB 16, 2001 | 3. Time of Death: 9:25 P.M. |
| 4a. Facility Name (If not institution, give street and number): 4314 Mountain Road | 4b. City, Town, or Location of Death: Pasadena | 4c. County of Death: Anne Arundel | |
| 5. Social Security Number: 212-14-8437 | 6. Sex: 1☐ M 2☒ F | 7. Age (In yrs. last birthday): 84 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.) | 8. Date of Birth (Month, Day, Year): 07/18/1916 |
| 9. Birthplace (State or Foreign Country): Maryland | | | |

**Usual Residence of Decedent**

| | | | |
|---|---|---|---|
| 10a. State: Maryland | 10b. County: Anne Arundel | 10c. City, Town or Location: Pasadena | 10d. Inside City Limits: 1☐ Yes 2☒ No |
| 10e. Street and Number: 4314 Mountain Road | 10f. Zip Code: 21122 | 10g. Citizen of What Country?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: | 14. Race - American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerical Worker | 16b. Kind of Business/Industry: Dept. of Motor Vehicles | |
| 17. Father's Name (First, Middle, Last): Elmer Hawkins | 18. Mother's Name (First, Middle, Maiden Surname): Mary Mercer | | |
| 19a. Informant's Name/Relationship (Type, Print): Alice Fay Tubman / Daughter | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4314 Mountain Road, Pasadena, Maryland 21122 | | |
| 20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery | Date: 02/24/01 | 20c. Location - City or Town, State: Baltimore, Maryland |
| 21. Signature of Funeral Service Licensee: Derrick C. Jones | 22. Name and Address of Facility: Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215 | | |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Arteriosclerotic Cardiovascular Disease | 5 years |
| | Due to (or as a consequence of): | |
| | b. Stroke | 1 year |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | |
| | c. Ischemic Heart Disease | 2 years |
| | Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

| | | |
|---|---|---|
| 29b. Signature and title of certifier: Elliott Gorbaty MD | 29c. License number: D20094 | 29d. Date signed (Month, Day, Year): 02/17/01 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elliott Gorbaty MD 7845 Oakwood Rd, Glen Burnie, Md. 21061

**State Registrar**

| | |
|---|---|
| 31. Date filed (Month, Day, Year): FEB 20 2001 | 32. Registrar's Signature: Donna G Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No: 2001 04925

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Norbert J. Tancibok Sr.

2. Date of Death Month Day Year: February 16, 2001

3. Time of Death: 5:05 AM

4a Facility Name *(If not institution, give street and number)*: Johns Hopkins Hospital Bayview

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 220-20-6960

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 2/7/1927

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5812 Plumer Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12); College (1-4or 5+): 2

16a. Decedent's Usuet Occupetion *(Give kind of work done duning most of working life. DO NOT use retired)*: Steel Estimator

16b. Kind of Business/Industry: Steel

17. Fether's Neme *(First, Middle, Last)*: Fabian Tancibok

18. Mother's Neme *(First, Middle, Maiden Surname)*: Helen Stasna

19a. Intorment's Neme/Reletionship *(Type, Print)*: Alma Tancibok/Wife

19b. Meiting Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 5812 Plumer Avenue Baltimore, Maryland 21206

20a. Method ot Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece ot Disposition *(Neme of cemetery, cremetory or other piece)*: Gardens of Faith

Dete: 2/19/01

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funerel Service Licensee: Carla R. [illegible]

22. Name end Address of Feciility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervet Between Onset end Deeth

Immediate Cause (Finel diseese or condition resulting in deeth)

a. Renal Failure

Due to (or as e consequence ot):

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

b. Hypertension

Due to (or es e consequence ot):

c.

Due to (or es e consequence ot):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete ot Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medcal Examiner**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [signature]

29c. License number: D43725

29d. Date signed *(Month, Day, Year)*: 2/16/01

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): TARIQ MAHMOOD 201-109 Back River Neck Rd Baltimore MD 21221

**State Registrar**

31. Dete filed *(Month, Dey, Yeer)*: FEB 2 0 2001

32. Registrer's Signeture: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04926

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): AMBROSE L. VASOLD
2. Date of Death (Month, Day, Year): FEB. 15, 2001
3. Time of Death: 6:00AM
4a. Facility Name (If not institution, give street and number): ST. AGNES NURSING & REHAB. CENTER
4b. City, Town, or Location of Death: ELLICOTT CITY
4c. County of Death: HOWARD COUNTY

**Funeral Director**

5. Social Security Number: 215-07-4631
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 19, 1909
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3603 HUDSON STREET
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINIST
16b. Kind of Business/Industry: MARTIN MARIETTA

17. Father's Name (First, Middle, Last): AMBROSE J. VASOLD
18. Mother's Name (First, Middle, Maiden Surname): ANNA JACOBS

19a. Informant's Name/Relationship (Type, Print): JAMES J. VASOLD/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 236 GLENBROOK DR., WESTMINSTER, MD. 21158

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SACRED HEART OF JESUS
Date: 2/19/01
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Robert A. Hancock M00521
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD.21224

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. CARDIAC ARRHYTHMIA | 5 MINUTES |
| Due to (or as a consequence of): | CORONARY ARTERY DISEASE | YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. | |
| Due to (or as a consequence of): | c. | |
| Due to (or as a consequence of): | d. | |

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: James C. Richardson MD
29c. License number: 027394
29d. Date signed (Month, Day, Year): 2/15/01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JAMES P. RICHARDSON M.D. 700 GEORGE ROAD, CATONSVILLE, MD 21228

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

10

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04927

DONALD WARD
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Donald Ward
2. Date of Death Month: 2 Day: 15 Year: 01
3. Time of Death: 12:20pm M
4e. Facility Name (If not institution, give street and number): 20 Dunvale Road, apt 105
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 215-32-8922
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 9, 1935
9. Birthplace (State or Foreign Country): Maryland

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 20 Dunvale Road, apt 105
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Automobile

17. Father's Name (First, Middle, Last): John Eugene Ward
18. Mother's Name (First, Middle, Maiden Surname): Hazel Gardner

19a. Informant's Name/Relationship (Type, Print): Karen A. Funk/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3309 Putty Hill Avenue, Baltimore, MD 21234

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore-Washington
Date: 2/17/01
20c. Location - City or Town, State: Crematory Laurel, Maryland

21. Signature of Funeral Service Licensee: Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia road, Timonium, MD 21093

**Physician /Medical Examiner**

**Medical Certification; To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Presumed myocardial infarction — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Cor pulmonale, hypoxia — years
Due to (or as a consequence of):
c. COPD, restrictive chest disease — years
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Howard Steiner
29c. License number: D 38403
29d. Date signed (Month, Day, Year): February 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Howard Steiner, MD 5601 Loch Raven Blvd., Morgan Building, suite 512, Baltimore Maryland, 21239

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

RJD
BRANDON WILKINS
01-939-510

1- For State Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04928

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Brandon Gordon Wilkins

2. Date of Death Month Dey Year: FEBUARY 18, 2001

3. Time of Death: 1954 P M

4e. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 214-90-6953

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 25 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08 30-1975

9. Birthpleca (State or Foreign Country): Maryland

Usuel Residenca of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1201 Rossiter Ave.

10f. Zip Code: 21239

10g. Citizen of Whaf Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Bteck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 th

College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Olson Wire Products

17. Father's Neme (First, Middle, Last): James Wilkins

18. Mother's Name (First, Middle, Maiden Surneme): Rosalind Williams

19e. Informent's Name/Reletionship (Type, Print): James Wilkins (Father)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1201 Rossiter Ave. Balto., Md. 21239

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Ptace of Disposition (Neme of cemetery, crernetory or other piece): Metro Crematory

Dete: 2/20/01

20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: Dennis B. Caple

22. Name and Address of Facility: Dennis B. Caple Funeral Home P.A. 4601 York Rd. Balto., Md. 21212

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Final diseese or condition resulting in deeth)

e. Gunshot wound of the right arm and chest

Due to (or as e consequenca of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequenca of):

d.

IF FEMALE:

23b. Was decedent pregnant in the pest 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of deeth 5 [ ] Other (specify) 9 [ ] Unknown

23d. Dete of delivery Month Day Year

Part II. **Other significant conditions** contributing to death buf not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Was en autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Yeer): 2-18-2001

28b. Time of Injury: 1920 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: subject was shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street

28f. Location (Street and Number or Rurel Route Number, City or Town, State): 707 Exeter Hall Baltimore City, Maryland

29e. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) end menner as steted. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Stuart L Nacht, M.D.

29c. License number: O.C.M.E.

29d. Dete signed (Month, Day, Year): FEBUARY 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No: 2001 04929

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: LORRAINE M WAGUS
2. Date of Death Month / Day / Year: FEB 14 2001
3. Time of Daeth: 5:27am

4a Facility Name *(If not institution, give street and number)*: 60 Dogwood Drive
4b. City, Town, or Location of Death: Wilson Point
4c. County of Deeth: Baltimore

**Funeral Director**

5. Social Security Number: 213-28-4291
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: March 1 1931
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Baltimore
10c. City, Town or Location: Wilson Point
10d. Ineide City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 60 Dogwood Drive
10f. Zip Code: 21220
10g. Citizen of What Country?: USA

11. Marital Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Amarican Indien, Black, White, etc. *Specify:* White

15. Decedant's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 11th | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: own home

17. Father's Neme *(First, Middle, Last)*: Lawrence Caldwell
18. Mother's Name *(First, Middle, Maiden Surneme)*: Margaret Hengemible

19a. Informent's Neme/Reletionship *(Type, Print)*: Edward Wagus / husband
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 60 Dogwood Drive Wilson Point MD 21220

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetary, cremetory or other place)*: Oak Lawn Cemetery Dete: 2/17/01
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly
22. Nama and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD 21221

**Physician /Medical Examiner**

23a. Pert1. Enter the diseasa, or complicetions thet caused tha death. Do not entar the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. — Approximate Intarval Batween Onsat and Death

Immedieta Causa (Final diseese or condition resulting in deeth)
a. Myocardial Infarction — minutes
Due to (or es e consequence of):
b. coronary artery disease — years
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings eveilable prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Placa of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residance 6☐ Othar *(Specify)*

27. Mennar of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and mennar as stated. 2☐ **Medical Examiner:** On tha besis of exemination and/or Investigation, in my opinion, deeth occurred et tha time, date and place, and dua to tha ceusa(s) and menner steted.

29b. Signatura and title of certifiar: ▶ Gregory W Branch
29c. Licensa number: D46194
29d. Date signed *(Month, Dey, Year)*: 2/14/01

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): Gregory Wm Branch 1245 EASTERN BLVD BALTIMORE 21221

**State Registrar**

31. Dete filed *(Month, Dey, Year)*: FEB 20 2001
32. Registrar's Signatura: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04930

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Hattie Wilson
2. Date of Death (Month, Day, Year): February 14 2001
3. Time of Death: 7:18AM
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

**Funeral Director**

5. Social Security Number: 212-22-8725
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min.
8. Date of Birth (Month, Day, Year): March 15, 1902
9. Birthplace (State or Foreign Country): South Carolina

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 301 McMechen St.
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 7 | College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Robert Foster
18. Mother's Name (First, Middle, Maiden Surname): Maggie Byrd

19a. Informant's Name/Relationship (Type, Print): Mr. Richard Foster (Brother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2454 Terra Firma Rd. Balto. Md. 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Crownsville Cem. Date: 2/20/2001
20c. Location - City or Town, State: Crownsville, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiomyopathy
Due to (or as a consequence of):
b. Dyslipidemia
Due to (or as a consequence of):
c. Arterial Hypertension
Due to (or as a consequence of):
d. Ca of Ovary

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Ca of Breast
Aneurysm Thoracic Aorta

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. Calderon
29c. License number: D 26656
29d. Date signed (Month, Day, Year): 02-16-01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JORGE CALDERON, M.D.

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: Denise G Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04931

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Preston Wenzing
2. Date of Death: Month: February Day: 13 Year: 2001
3. Time of Death: 5:46pm
4a. Facility Name (If not institution, give street and number): Veterans Affairs Hospital
4b. City, Town, or Location of Death: Baltimore, MD
4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 216-52-6060
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 52 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 1, 1948
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3806 Dorchester Road
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: '67-70
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): glass mechanic
16b. Kind of Business/Industry: automotive

17. Father's Name (First, Middle, Last): Albert Charles Wenzing
18. Mother's Name (First, Middle, Maiden Surname): Helen May Mulenburg

19a. Informant's Name/Relationship (Type, Print): Robert W. Wenzing/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 Leslie Avenue Baltimore, MD 21236

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumothorax
Due to (or as a consequence of):
b. Respiratory Distress
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Chronic obstructive Pulmonary Disease.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Depression.
Alcohol Abuse

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: AU41764351H13126
29d. Date signed (Month, Day, Year): February 13, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vikram Hathi M.D., 10 North Grove St., Baltimore, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: Geneva G Sparks

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04932

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WALLACE W. WHITMIRE

2. Date of Death: Month 2 Day 18 Year 01

3. Time of Death: 5:29 AM

4a. Facility Name (If not institution, give street and number): 3241 Kessler Road

4b. City, Town, or Location of Death: Arbutus

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 213-16-3948

6. Sex: 1☑ M 2☐ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 16, 1921

9. Birthplace (State or Foreign Country): South Carolina

Usual Residance of Decedant

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3241 Kessler Road

10f. Zip Code: 21227

10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Welder

16b. Kind of Business/Industry: Ship Building

17. Father's Name (First, Middle, Last): Luther C. Whitmire

18. Mother's Name (First, Middle, Maiden Surname): Flora S. Wills

19a. Informant's Name/Relationship (Type, Print): Irene L. Whitmire - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3241 Kessler Road, Arbutus, Maryland 21227

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Data: 2/21/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Ann Y. Zink

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. COLON CANCER ~2yrs

Due to (or as a consequance of):
b. CONGESTIVE HEART FAILURE ~5yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequance of):
c. COMPLETE HEART BLOCK ~10yrs

Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Hsieh

29c. License number: D50533

29d. Date signed (Month, Day, Year): 2/19/01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Russell Hillsley, Suite 300, 3449 Wilkens Avenue, Baltimore, Maryland 21229

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: B. Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04933

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Elmo J. Williams

2. Date of Death: Month FEB Day 15 Year 2001

3. Time of Death: 1:05 pm

4a. Facility Name (If not institution, give street and number): ST. AGNES HEALTHCARE 900 CATON AVENUE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: 240-44-4768

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11 20 27

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4200 Flowerton Road

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd grade; Collega (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mill Worker

16b. Kind of Business/Industry: Lumber Yard

17. Father's Name (First, Middle, Last): Mack Williams

18. Mother's Name (First, Middle, Maiden Surname): CoWillie Artis

19a. Informant's Name/Relationship (Type, Print): Mattie Williams-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4200 Flowerton Road, Baltimore Md 21229

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park Date: 2/20/01

20c. Location - City or Town, State: Arbutus, Md

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. OVERWHELMING SEPSIS

Due to (or as a consequence of): b. EMPYEMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. INTRA-ABDOMINAL ABSCESS

Due to (or as a consequence of): d. IMMUNOSUPPRESSION.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] PGY-II SURGERY RESIDENT

29c. Licansa number: AS2438528187

29d. Date signed (Month, Day, Year): FEB 15 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.L. GANTI, ST. AGNES HEALTHCARE, 900 CATON AVENUE, BALTIMORE, MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important:** If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME ELMO WILLIAMS

6

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04934

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): WILLIAM H. WASHINGTON
2. Date of Death Month: 02 Day: 11 Year: 2001
3. Time of Death: 16:02
4a Facility Name (If not institution, give street and number): 3727 Oak Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

**Funeral Director**

5. Social Security Number: 216-34-8382
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-31-1939
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Balto
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3727 Oak Avenue
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): 2 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Staff Sargeant
16b. Kind of Business/Industry: Army

17. Father's Name (First, Middle, Last): James William Washington
18. Mother's Name (First, Middle, Maiden Surname): Cecelia Jennifer

19a. Informant's Name/Relationship (Type, Print): Gloria J. Washington-Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3727 Oak Avenue Balto, Md 21207

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet | Date: 2-15-01
20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: March F. H. West 4300 Wabash Avenue Balto, Md 21215

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final diseese or condition resulting in death) a. | Myocardial Infarction | Minutes |
| Due to (or as a consequence of): b. | Coronary artery disease | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Hypertension, Smoking | years |
| d. | | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Carotid artery disease; Peripheral vascular disease

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A. Heman M.D
29c. License number: D0041514
29d. Date signed (Month, Day, Year): 2/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALNOOR G. HEMANI, M.D. 10. N. Green St. Baltimore, MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at this**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04935

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: VIOLET NUNAN WILKES

2. Date of Death Month Day Year: February 17, 2001

3. Time of Death: 10:25 P.M.

4a. Facility Name *(If not institution, give street and number)*: Presbyterian Home of Maryland

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 216-12-2842

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 19, 1903

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 400 Georgia Court

10f. Zip Code: 21204

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4 years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Servant

16b. Kind of Business/Industry: Army Intelligence

17. Father's Name *(First, Middle, Last)*: Robert Nunan

18. Mother's Name *(First, Middle, Maiden Surname)*: Rosamond Levi

19a. Informant's Name/Relationship *(Type, Print)*: Jean Arnold (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14611 Algretus Drive Centreville, Virginia 20120

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery

Date: 2-20-01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: George J. Ferrare

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute Myocardial Infarction — one day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending MD

29c. License number: 037016

29d. Date signed *(Month, Day, Year)*: February 19, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Kenneth M. Greene, MD 6701 N. Charles St, Suite 4105 Baltimore, MD 21204

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified all cases.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

01-0849-005
crn
David Widmaier

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED# 23 &27 per ME G793 031401 SS

# Certificate of Death

Reg. No. 2001 04936

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: DAVID KERT WIDMAIER

2. Date of Death Month Day Year: February 14, 2001

3. Time of Death: 1:45 P M

4a. Facility Name *(If not institution, give street and number)*: 1600 Mussula Road

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 218-62-1052

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 1, 1952

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Towson

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1600 Mussula Road

10f. Zip Code: 21286

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance Mechanic

16b. Kind of Business/Industry: Baltimore County Board of Education

17. Father's Name *(First, Middle, Last)*: John Vladamir Widmaier

18. Mother's Name *(First, Middle, Meiden Surname)*: Dorothy Marie Miller

19a. Informant's Name/Relationship *(Type, Print)*: Kathy Kalista Widmaier (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3006 California Avenue, Parkville, Maryland 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Dulaney Valley Mem Grdns

Date: 2/19/2001

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other *(Specify)* at scene

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification; To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Clifton Locke, MD

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: February 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Clifton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 20 2001

32. Registrar's Signature: pending D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04937

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Virginia E. Wilburt

2. Date of Death (Month, Day, Year): February 13 2001

3. Time of Death: 1240 p.m.

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel Co.

**Funeral Director**

5. Social Security Number: 578-18-7688

6. Sex: 1☐ M 2☒ F XX

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8/31/20

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No XX

10e. Street and Number: 8063 Longbranch Ter. #T-4

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed XX 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Westinghouse

17. Father's Name (First, Middle, Last): John M. Renwick

18. Mother's Name (First, Middle, Maiden Surname): Fannie Rae Bayless

19a. Informant's Name/Relationship (Type, Print): Richard W. Wilburt - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1006 Louise Drive, Glen Burnie, MD 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington NAt. Cem.

Date: 2/23

20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: Kelly Gregory Fink MD 148

22. Name and Address of Facility: FINK FUNERAL HOME, PA
426 Crain HWy., SW, Glen Burnie, MD 21061

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Recurrent Parotid Gland Carcinoma — months

Due to (or as a consequence of):
b. Carcinoma invasion of the Brainstem — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Respiratory Arrest — 5 minutes

Due to (or as a consequence of):
d. Acute Anuric Renal failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
Congestive Heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 032654

29d. Date signed (Month, Day, Year): February 13, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John Serlemitsos 301 Hospital Drive, Glen Burnie, MD 21061

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 04938

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Wilbon

2. Date of Death Month Day Year: Feb. 13, 2001

3. Time of Death: 10:15PM

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 579-30-0571

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 20, 1915

9. Birthplace (State or Foreign Country): Tignall, GA.

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1091 Ruatan Street

10f. Zip Code: 20903

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: self employed

17. Father's Name (First, Middle, Last): Willie Anderson

18. Mother's Name (First, Middle, Maiden Surname): Minnie Henderson

19a. Informant's Name/Relationship (Type, Print): Dorothy Moton/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5724 3rd Pl N.W. Washington, D.C. 20011

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Cemetery

Date: 2-17-01

20c. Location - City or Town, State: Suitland, Md.

21. Signature of Funeral Service Licensee: J. P. Marshall

22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington,D.C. 20011

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- SEVERE SYSTOLIC DYSFUNCTION; RENAL FAILURE
- DIABETES MELLITUS; HYPERTENSION;
- CONGESTIVE HEART FAILURE; SEPSIS SYNDROME

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Gopamsundar MD

29c. License number: D0053367

29d. Date signed (Month, Day, Year): 2.14.2001.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 10810 DARNESTOWN ROAD, SUITE: 202, GAITHERSBURG, MD: 20878.

**State Registrar**

31. Date filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: G Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 48 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and the Funeral Director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04939

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Anita Ward

2. Date of Death Month Day Year: Feb. 14, 2001

3. Time of Death: 9:20 A.M.

4a. Facility Name (If not institution, give street and number): 8103 Eastern Ave Apt. 206

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 579-46-0028

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 29, 1930

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8103 Eastern Ave. #206

10f. Zip Code: 20910

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: AARP

17. Father's Name (First, Middle, Last): Chester Chichester

18. Mother's Name (First, Middle, Maiden Surname): Theresa Coates

19a. Informant's Name/Relationship (Type, Print): Jocelyn Ward/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1230 Crittenden St. N.W. Washington, DC 20011

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Lincoln Memorial Cemet

Date: 02-19-01

20c. Location - City or Town, State: Suitland, MD.

21. Signature of Funeral Service Licensee: J. P. Marshall

22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington,DC 20011

**Physician /Medical Examiner**

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James Cockrell, M.D.

29c. License number: 44571

29d. Data signed (Month, Day, Year): 02/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Cockrell, M.D. 7600 Carroll Ave. Takoma Park, Md.

**State Registrar**

31. Data filed (Month, Day, Year): FEB 16 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04940

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| HILDA | L. | WAGNER | FEBRUARY 16, 2001 | 1:40 AM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| HOSPICE OF BALTIMORE - GILCHRIST CENTER | TOWSON | BALTIMORE |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-14-9545 | 1☐ M 2☒ F | 79 Yrs. | | | NOV.11,1921 | MD |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | BALTIMORE | BALTIMORE | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 7 SLADE AVENUE #421 | 21208 | U.S.A. |

| 11. Meritet Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Yeer or Detes: | 1☐ Yes 2☒ No *Specify:* | *Specify:* WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | BUYER | CLOTHING |

| 17. Fether's Neme (First, Middle, Last) | | 18. Mother's Neme (First, Middle, Maiden Surname) | |
|---|---|---|---|
| GOEL | BLOOM | JENNIE | ZIMMERMAN |

| 19e. Informent's Neme/Reletionship (Type, Print) | 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CHARLES WAGNER / HUSBAND | 7 SLADE AVENUE #421 - BALTIMORE, MD 21208 |

| 20e. Method of Disposition | 20b. Place of Disposition (Neme of cemetery, crematory or other piece) | Dete | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒ Burial 2☐ Cremetion 3☐ Removel from Stale 4☐ Donelion 5☐ Other (Specify) | BETH EL MEMORIAL PARK | 2/18/01 | RANDALLSTOWN, MD |

21. Signature of Funerel Service Licensee ▶ Jay Alan Lewis

22. Neme end Address of Fecility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or hert failure. List only one cause on eech line.

| | | Approximete Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. Breast Cancer | 4 years |
| | Due to (or es a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last | b. Due to (or es e consequence of): | |
| | c. Due to (or es e consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did **tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Wes an eutopsy performed? | 24b. Were eutopsy tindings aveilable prior to completion of cause of deeth? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Wes case referred to medical examiner? | 26. Place of Deeth (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice |

| 27. Manner of Death | 28a. Dete of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner es steted.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted.

| 29b. Signeture end title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ A. Anthony Riley, MD | D25205 | February 16, 2001 |

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

**State Registrar**

| 31. Dete filed (Month, Day, Year) | 32. Registrer's Signeture |
|---|---|
| FEB 20 2001 | ▶ D. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Hilda Wagner February 16, 2001 0150AM

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

10

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04941

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: MARY WOLF
2. Data of Death Month / Day / Yaar: FEB. 13, 2001
3. Tima of Daath: 9:20 PM
4a. Facility Nama *(If not institution, giva street and number)*: 6719 DANVILLE AVE.
4b. City, Town, or Location of Daath: DUNDALK
4c. County of Death: BALTIMORE

**Funeral Director**

5. Social Sacurity Number: 219-18-2061
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: JAN. 8, 1923
9. Birthplace *(Stata or Foraign Country)*: W. VIRGINIA

Usual Rasidence of Decedent

10a. Stata: MD.
10b. County: BALTIMORE
10c. City, Town or Location: DUNDALK
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 6719 DANVILLE AVE.
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Dacedant Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yas 2☒ No *Specify:*
14. Raca - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grade complatad)*: Elementary/Secondary (0-12): 11TH — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: SALES PERSON
16b. Kind of Businass/Industry: RETAIL

17. Father's Nama *(First, Middla, Last)*: VASILIOS DOXANAS
18. Mothar's Nama *(First, Middla, Maidan Surname)*: SOPHIA KARABETSOS

19a. Informant's Name/Ralationship *(Type, Print)*: JOSEPH WOLF, III/SON
19b. Mailing Addrass *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 67 BLOCK BLVD., MASSAPEQUA PARK, NY 11762

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: BALTIMORE WASHINGTON CREMATORY — Date: 2/16/01
20c. Location - City or Town, Stata: LAUREL, MD.

21. Signatura of Funaral Sarvica Licansaa: Richard L Stennett M0054
22. Nama and Addrass of Faciliity: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

**Physician /Medical Examiner**

23a. Part I. Entar tha disaasa, or complications thet causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart faitura. List only one ceusa on aach line.

Approximata Interval Batwaan Onset and Death

Immediate Ceusa (Final disease or condition resulting in death): a. Gastric adenocarcinoma. — unknown

Dua to (or as a consaquanca of):

Sequantially tist conditions, if any, leading to immadiata ceusa. Entar Undarlying Causa (Diseasa or Injury that initiatad avants rasulting in death) Last:
b.
Dua to (or as a consaquanca of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings availabla prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Wes casa rafarrad to medical examinar? 1☐ Yes 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Daath: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Placa of Injury - At home, farm, street, factory, office building, atc. *(Spacify)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Data of Injury *(Month, Day Year)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowladga, daath occurrad at tha tima, data and placa, and due to the ceuse(s) and manner as stated.
2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at the time, data and placa, and due to tha ceuse(s) and manner stated.

29b. Signatura and title of cartifiar: P Baltatzis jr MD
29c. Licansa number: D0028949
29d. Data signad *(Month, Day, Year)*: 2/15/01

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): Panayiotis A. Baltatzis, M.D. 1232 Race Rd. Ste 202 Rosedale, Md 21237

**State Registrar**

31. Data filad *(Month, Day, Year)*: FEB 20 2001
32. Registrar's Signatura: Brenda G Sparks

10

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-0756-510
jhm
ANTHONY
ZISK

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND#20b&c PER F.H. G792 2-20-2001 JAB

# Certificate of Death

Reg. No: 2001 04942

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ANthony Zisk

2. Date of Death: Month FEBRUARY Day 09, Year 2001

3. Time of Death: 14:47 PM

4a. Facility Name (If not institution, give street and number): JOHN HOPKINS BAYVIEW HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

**Funeral Director**

5. Social Security Number: 219-52-8782

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-14-48

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County:

10c. City, Town or Location: BALTO.

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 3225 Ester Place

10f. Zip Code: 21224

10g. Citizen of What Country? U S A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1970 1976

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disable Vet

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): ANthony Zisk Sr.

18. Mother's Name (First, Middle, Meiden Surname): IRene CraIg

19a. Informant's Name/Relationship (Type, Print): PATRICIA ROBINSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 603 S. Bouldin St. BALTO. Md. 21224

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): OAK LAWN CEMETERY GARRISON Forest

Date: 2-26-01

20c. Location - City or Town, State: EASTERN AVE. BALTO. MD. ~~REISTERSTOWN MD~~

21. Signature of Funeral Service Licensee: Wesley Chavis Jr

22. Name and Address of Facility: CHAVIS F.H. 2007 EASTERN AVE. BALTO. MD. 21231

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dilated Cardiomyopathy.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent et time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were eutopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and dua to the causa(s) end manner stated.

29b. Signature and title of certifier:

29c. License number: OCME

29d. Date signed (Month, Day, Year): FEBRUARY 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 2 0 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Medical Certification; To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To Be Completed by Funeral Director**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04943

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mabel G. Zepp
2. Date of Death (Month, Day, Year): February 17, 2001
3. Time of Death: 9:17 PM
4a. Facility Name (If not institution, give street and number): Deaton Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

**Funeral Director**

5. Social Security Number: 220-74-0524
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 8, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4211 Parkmont Ave
10f. Zip Code: 21206
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): n/a
16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): James Oliver Zepp
18. Mother's Name (First, Middle, Maiden Surname): Sarah Frances Sullivan

19a. Informant's Name/Relationship (Type, Print): Mrs. Rachel E. Smith/sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4211 Parkmont Ave. Baltimore, MD 21206

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. | Date: 02/23/2001
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Stephen D. coster MD1122
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Stroke | 1 hr |
| Due to (or as a consequence of): | b. Atherosclerotic vascular disease | 15 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): c. | |
| | Due to (or as a consequence of): d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Asthma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D38675
29d. Date signed (Month, Day, Year): 2/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOEL MESHULAM 301 ST PAUL PL SUITE 605 BALTIMORE MD 21202

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04944

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Deborah Ann Aylor

2. Date of Death Month: January Day: 30 Year: 2001

3. Time of Death: 1945

4a. Facility Name *(If not institution, give street end number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 220-74-0459

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 41 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: 10-20-1959

9. Birthplece *(Stete or Foreign Country)*: Md.

Usuel Residence of Decedent

10a. State: Md.

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 926 Snow Hill Rd.

10f. Zip Coda: 21801

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☒ Never Merried 2☐ Merried 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 0 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: never worked

16b. Kind of Business/Industry: none

17. Fethar's Neme *(First, Middle, Last)*: Delma A. Aylor, Sr.

18. Mother's Name *(First, Middle, Meiden Surneme)*: Anna McGovern Libby

19a. Informent's Name/Reletionship *(Type, Print)*: Anna Libby, Mother

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1509 Tulip Dr. Salisbury, Md. 21804

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crametory or othar piece)*: Meadowridge Cemetery

Dete: 2-5-01

20c. Location - City or Town, Stete: Elkridge, Md.

21. Signetura of Funaral Sarvice Licensee: [signature]

22. Nama end Addrass of Facility: Short Funeral Home, 13 E. Grove St. Delmar, De. 19940

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in deeth)

a. Sepsis

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leeding to immadiate ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last

b. Urinary Tract infection.

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying cause given in Part I.

Pancreatitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examinar? 1☐ Yas 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and piece, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: [signature] R. Cok Do

29c. Licensa number: H005197

29d. Date signed *(Month, Day, Year)*: 1/31/01

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): 100 E. Carroll St Salisbury MD 21801 Dr. Robert Coker

**State Registrar**

31. Dete filed *(Month, Dey, Year)*: FEB 05 2001

32. Registrer's Signeture: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To Be Completed by Funeral Director**

Deborah Aylor

JWP

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04945

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|---|---|
| ASA | T. | BUNDICK | February 2, 2001 | 0730 |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months | If Under 1 Year: Days | If Under 24 Hrs.: Hours | If Under 24 Hrs.: Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 231-54-7559 | 1☒ M 2☐ F | 56 Yrs. | | | | | SEPT. 23, 1944 | VIRGINIA |

**Usual Residence of Decedent**

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MARYLAND | WICOMICO | SALISBURY | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 179 EMILY DR. | 21804 | U.S.A. |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No *Specify:* | *Specify:* WHITE |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | REGIONAL SALES MANAGER | ELECTRICAL SUPPLY CO. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| CHARLES ELDON BUNDICK | HELEN BRITTINGHAM |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| PROVIDENCE J. BUNDICK - WIFE | 179 EMILY DR. SALISBURY, MD 21804 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | PARSONS CEMETERY | 2/6/01 | SALISBURY, MARYLAND |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ B. Keyst Phipps CFSP | 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 |

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | e. ACUTE PULMONARY EMBOLUS | HOURS |
| | Due to (or as a consequence of): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): | |
| | c. Due to (or as a consequence of): | |
| | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined | | M | 1☐ Yes 2☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Ronald P. Trautrend MD | D36576 | 2/6/01 |

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
RONALD P. TRAUTREND 560 RIVERSIDE DR SALISBURY MD 21801

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 06 2001 | ▶ Geneva B Sparks |

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

231-54-7559
Asa T. Bundick
12DQ

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

Amend Item 29d per Physician 02/06/2001, Carroll County, wjl

# State of Maryland / Department of Health and Mental Hygiene
## Certificate of Death

Reg. No. 2001 04946

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ann Ilene Boerner
2. Date of Death (Month, Day, Year): February 5 2001
3. Time of Death: 1:10 AM
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll County

**Funeral Director**

5. Social Security Number: 213-36-9926
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 23,1939
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Upperco
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5231 Byerly Road
10f. Zip Code: 21155
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: white

15. Decedent'a Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Payroll Administration
16b. Kind of Business/Industry: Concrete Company

17. Father's Name (First, Middle, Last): Harry G. Redsecker
18. Mother's Name (First, Middle, Maiden Surneme): Alma G. Kaiser

19e. Informent's Name/Relationship (Type, Print): Gerald Boerner Sr, husband
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 5231 Byerly Rd, Upperco, MD 21155

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): St. Paul's Cemetery
Date: 2/08 2001
20c. Location - City or Town, State: Arcadia, MD

21. Signature of Funeral Service Licensee: Steven W Eline MO0723
22. Name end Address of Facility: Eline Funeral Home 934 South Main St, Hampstead, MD 21074

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multisystem organ failure — days

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last:
b. Metastatic lung cancer — months
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part fl. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describa how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Hwan Yong Yoo, M.D.
29c. License number: D0053514
29d. Date signed (Month, Day, Year): February 5, 2001 ~~February 5, 1991~~

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Hwan Y. Yoo, M.D. Carroll County General Hospital, Westminster, MD

**State Registrar**

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** Tha law requires that tha daath certificata be executed within 24 hours after daath.
**To the Funeral Director:** Aftar this cartificate has been signed by tha attending physician and completely filled in by tha funaral director, page 2 should be detached lor use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Ann I Boerner
Baltimore, Maryland 21215-0020

**Division of Vital Records, P.O. Box 68760,**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04947

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARILYN E. BERTRAND
2. Date of Death (Month, Day, Year): JANUARY 31, 2001
3. Time of Death: 1:00 A.M.
4a. Facility Name (If not institution, give street and number): 12309 N. PINEY POINT ROAD
4b. City, Town, or Location of Death: BISHOPVILLE
4c. County of Death: WORCESTER

**Funeral Director**

5. Social Security Number: 214-68-6635
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-5-1955
9. Birthplace (State or Foreign Country): DELAWARE

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: WORCESTER
10c. City, Town or Location: BISHOPVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12309 N. PINEY POINT ROAD
10f. Zip Code: 21813
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): WALTER HUDSON
18. Mother's Name (First, Middle, Maiden Surname): HAZEL SMACK

19a. Informant's Name/Relationship (Type, Print): ALLAN J. BERTRAND/ HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12309 N. PINEY POINT RD. BISHOPVILLE, MD. 21813

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MARINER'S BETHEL CEMETERY | Date: 2-2-01
20c. Location - City or Town, State: OCEAN VIEW, DELAWARE

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: MELSON FUNERAL SERVICES, LTD. 43 THATCHER ST. FRANKFORD, DELAWARE. 19945

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: C2000089
29d. Date signed (Month, Day, Year): Jan 31, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): FAITH JABERS MATZONI., 1209 COASTAL HIGHWAY, FENWICK ISLAND, DELAWARE. 19944

**State Registrar**

31. Date filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04948

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GENEVIEVE LUCILLE BRECKENRIDGE

2. Date of Death: Month JANUARY Day 26, Year 2001

3. Time of Death: 6:20 A.M.

4a. Facility Name (If not institution, give street and number): BERLIN NURSING & REHAB CENTER

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WORCESTER

**Funeral Director**

5. Social Security Number: 213-30-8262

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7-15-33

9. Birthplace (State or Foreign Country): VA.

Usual Residence of Decedent

10a. State: MD.

10b. County: WORCESTER

10c. City, Town or Location: BERLIN

10d. Insida City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 9523 OLD OCEAN CITY BLVD.

10f. Zip Code: 21811

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER

16b. Kind of Business/Industry: OWN HOME

17. Fethar's Nema (First, Middle, Last): BRUCE COMPTON

18. Mother's Neme (First, Middle, Maiden Surneme): ALICE MADY SKEENS

19e. Informent's Name/Relationship (Type, Print): ALICE LUCILLE ELLIOTT

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 9523 OLD OCEAN CITY BLVD. BERLIN, MD. 21811

20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): CEDAR HILL CEMETERY

Dete: 1-31

20c. Location - City or Town, Stete: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: John L. Ullrich

22. Nama end Address of Fecility: ULLRICH FUNERAL HOME BERLIN, MD. 21811

**Physician /Medical Examiner**

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Finel disaase or condition resulting in death)

e. Congestive Health Failure 2yrs.

Due to (or es e consequence of):

b. Coronary Artery Disease

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest

Due to (or es e consequence of):

c. Diabetes Mellitus Insulin Dep 7yrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Part I.

Coronary by Pass (4 Vessel)
Bilateral Mastectomy @ 1
Breast Implants.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☒ No

25. Wes cese referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residance 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Dascribe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Streat and Numbar or Rurel Route Numbar, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or invastigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: [signature]

29c. License number: D02026

29d. Date signed (Month, Dey, Year): JAN 26 -01

30. Nama and address of person who completed ceuse of deeth (Item 23e) (Type, Print): DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD. 21811

**State Registrar**

31. Data filed (Month, Day, Year): FEB 05 2001

32. Registrer's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

BRECKENRIDGE, GENEIVIVE
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04949

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| FOY | M | BUCHANAN | January 29, 2001 | 14:20 |

| 4a. Facility Name (If not institution, give street end number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 516 Georgia Ave., Apt. H | Salisbury | Wicomico |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Dey, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 260-01-2560 | 1☒ M 2☐ F | 80 Yrs. | | | June 9, 1920 | Georgia |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Wicomico | Salisbury | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 516 Georgia Ave., Apt. H | 21801 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☐ No If Yes, Give Year or Dates: unknown | 1☐ Yes 2☒ No *Specify:* | *Specify:* White |

| 15. Decedent's Eduction (Specify only highest grede completed) | | 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondery (0-12) | College (1-4or 5+) | | |
| unknown | | Manager | Finance |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Neme (First, Middle, Maiden Surneme) |
|---|---|
| Mott McKinley Buchanan | Lola Neal |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) |
|---|---|
| Orville & Esther Outten/Friends | 621 Outten Rd., Salisbury, MD 21801 |

| 20e. Method of Disposition | 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) | Dete | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify) | Wicomico Memorial Park | 2-5-2001 | Salisbury, Maryland |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Michael A Dean M01129 | Holloway Melson Funeral Home, P.A. 103 Linden ave., Pocomoke City, MD 21851 |

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Finel diseese or condition resulting in deeth)
e. Acute Myocardial infarction

Due to (or as e consequence of):
b. Hypertension. 15yrs.

Sequentially list conditions, if eny, leading to Immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

Due to (or as e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Severe Depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were eutopsy findings available prior to completion of ceuse of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☐ No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Was case referred to medicel examiner? | 26. Piece of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) |

| 27. Menner of Deeth | 28a. Dete of Injury (Month, Dey Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) |
|---|---|
| | |

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the cause(s) and menner as stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

| 29b. Signeture end title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Year) |
|---|---|---|
| ▶ | D15192 | 1/30/01 |

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)
Dr. Joseph Badros, M.D.- 813B Eastern Shore Dr., Salisbury, MD 21804

**State Registrar**

| 31. Date filed (Month, Dey, Year) | 32. Registrer's Signeture |
|---|---|
| FEB 01 2001 | Jennie G. Sparks |

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DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No 2001 04950

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MILTON G BIEDERMAN
2. Date of Death (Month, Day, Year): FEB 08 01
3. Time of Death: 1255pm
4a. Facility Name (If not institution, give street and number): COPPERRIDGE
4b. City, Town, or Location of Death: SYKESVILLE
4c. County of Death: CARROLL

**Funeral Director**

5. Social Security Number: 288-03-1485
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01/20/1916
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 710 Obrect Road
10f. Zip Code: 21784
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Photolab Chief
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Frank Biederman
18. Mother's Name (First, Middle, Meiden Surname): Frances Eismann

19a. Informant's Name/Reletionship (Type, Print): Michael Biederman/Son
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 2227 Dulany Terr. Westminster, MD 21157

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Arlington National
Date: 2/15/01
20c. Location - City or Town, State: Arlington, VA

21. Signeture of Funeral Service Licensee: [signature] 00387
22. Name and Address of Facility: CUNNINGHAM FUNERAL HOME P.O. BOX 65 ALEXANDRIA, VA 22313

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth): e. PNEUMONIA WITH SEPSIS

Due to (or as e consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DECUBITUS ULCER

ALZHEIMERS DEMENTIA

DIABETES II

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature] — JACOB LEVINE
29c. License number: D48189
29d. Date signed (Month, Dey, Year): FEB 8 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 710 OBRECHT RD, SYKESVILLE MARYLAND 21784

**State Registrar**

31. Date filed (Month, Day, Year): FEB 20 2001
32. Registrar's Signature: [signature] Geneva G Sparks

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04951

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: HELEN THERESA BISHOP
2. Date of Death Month / Day / Year: FEBRUARY 6, 2001
3. Time of Death: 01:00 A.M.
4a. Facility Name *(If not institution, give street and number)*: CALVERT MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: PRINCE FREDERICK
4c. County of Death: CALVERT

**Funeral Director**

5. Social Security Number: 220-12-4015
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 02-01-1913
9. Birthplace *(State or Foreign Country)*: BOSTON, MA

Usual Residence of Decedent

10a. State: MD
10b. County: CALVERT
10c. City, Town or Location: SOLOMONS
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13325 DOWELL ROAD
10f. Zip Code: 20688
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest greda completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRAVEL CLERK
16b. Kind of Business/Industry: U.S. GOVERNMENT

17. Father's Neme *(First, Middle, Last)*: JOHN E. HIGGINS
18. Mother's Name *(First, Middle, Maiden Surname)*: MELVINA DeLORES

19a. Informant's Name/Reletionship *(Type, Print)*: MRS. JEAN H. COX (DAUGHTER)
19b. Malling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. BOX 92 DOWELL, MD 20629

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetary, cremetory or other piece)*: RESURRECTION MEMORIAL | Date: 2-10-01
20c. Location - City or Town, State: CLINTON, MARYLAND

21. Signature of Funeral Service Licensee: Mark G Brohawn
MARK G. BROHAWN M00053

22. Name and Address of Facility: HUNTT FUNERAL HOME INC. 3035 OLD WASHINGTON ROAD WALDORF, MARYLAND

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line. | Approximate Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequenca of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseasa or injury thet initieted events resulting in death) Last
b.
Due to (or es a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings eveilable prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to tha cause(s) end manner steted.

29b. Signature and title of certifier:
29c. License number: D0052242
29d. Date signed *(Month, Dey, Year)*: 2-06-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. Joseph Barth, MD Prince Frederick, MD 20678

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 08 2001
32. Registrar's Signature: Penne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04952

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: LILA J. BROWN

2. Date of Death Month / Day / Year: JANUARY 27 2001

3. Time of Death: 5:45pm

4a. Facility Name *(If not institution, give street and number)*: RENAISSANCE GARDENS

4b. City, Town, or Location of Death: BALTO.

4c. County of Death: BALTO.

**Funeral Director**

5. Social Security Number: 258-50-4628

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 20, 1903

9. Birthplace *(State or Foreign Country)*: SC

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8832 Walther Boulevard

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Missionary

16b. Kind of Business/Industry: Presbyterian Church

17. Father's Name *(First, Middle, Last)*: William E. Brown

18. Mother's Name *(First, Middle, Maiden Surname)*: Amanda Mobley

19a. Informant's Name/Relationship *(Type, Print)*: Sara B. Cordery/Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 21234: 8820 Walther Blvd, Apt. 2208, Parkville, MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Stewartstown Cemetery

Date: Jan. 31, 2001

20c. Location - City or Town, State: Stewartstown, PA

21. Signature of Funeral Service Licensee: J.J. Hartenstein

22. Name and Address of Facility: J.J. Hartenstein Mortuary, Inc. 19 S. Main St., Stewartstown, PA 17363

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Vascular Accident — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Peripheral Vascular Disease — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Fredric S. Sirkis MD

29c. License number: D22645

29d. Date signed *(Month, Day, Year)*: 1/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FREDRIC S. SIRKIS M.D. 8800 WALTHER BLVD. PARKVILLE, MD. 21234

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 6 2001

32. Registrar's Signature: P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

AMEND#26 2-6-2001 LM HCHD

Reg. No. 2001 04953

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Patricia Louise Benser
2. Date of Death (Month, Day, Year): Feb. 3, 2001
3. Time of Death: 7:00 a.m.
4a. Facility Name (If not institution, give street and number): 145 Remington Circle
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 212-28-1162
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 8, 1928
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Edgewood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2307 Perry Avenue
10f. Zip Code: 21040
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Invoice Clerk
16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): Culp McClure Cummings
18. Mother's Name (First, Middle, Maiden Surname): Helen (u/k) Henry

19a. Informant's Name/Relationship (Type, Print): Susan N. Benser- Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Popular Terrace , Delta, Pennsylvania 17314

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity Lutheran Cemetery
Date: 2/6/01
20c. Location - City or Town, State: Joppa, Maryland

21. Signature of Funeral Service Licensee: Stephen A. Hughes
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. METASTATIC NON-SMALL LUNG CANCER — 8 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ ~~Residence~~ 6☒ Other (Specify) son' residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Auerbach
29c. License number: D33551
29d. Date signed (Month, Day, Year): FEB. 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael AUERBACH 9000 FRANKLIN SQ. DR., BALTIMORE 21237

**State Registrar**

31. Date filed (Month, Day, Year): FEB 6 2001
32. Registrar's Signature: B. Sparks

10

**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04954

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Frank C. Bobart Jr.

2. Date of Death: Month February, Day 11, Year 2001

3. Time of Death: 8:44am

4a. Facility Name (If not institution, give street and number): Gilchrist Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 212 34 0639

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Apr 21, 1935

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 5506 Montgomery Road

10f. Zip Code: 21043

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Budget Analyst

16b. Kind of Business/Industry: Westinghouse

17. Father's Name (First, Middle, Last): Frank C. Bobart Sr.

18. Mother's Name (First, Middle, Maiden Surname): Myrtle M. Campbell

19a. Informant's Name/Relationship (Type, Print): Dorothy M. Bobart/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5506 Montgomery Road Ellicott City, MD 21043

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Lutheran Cem. Date: 2-14-2001

20c. Location - City or Town, State: Columbia, MD

21. Signature of Funeral Service Licensee: Shawn a Collins-Witzke MD044

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Bladder cancer — 8 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): February 11, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): W.A. Riley GBMC 6701 N Charles St. Balto. Md 21204

**State Registrar**

31. Date filed (Month, Day, Year): FEB 12 2001

32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8:44AM 2/11/01 Bobart, Frank (2)

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04955

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Woodrow Francis Crumbacker
2. Date of Death (Month, Day, Year): Feb. 2, 2001
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, give street and number): 2175 Dennings Rd.
4b. City, Town, or Location of Death: New Windsor
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 215-32-2336
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 3, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: New Windsor
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2175 Dennings Rd.
10f. Zip Code: 21776
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): Arthur P. Crumbacker
18. Mother's Name (First, Middle, Maiden Surname): Carrie Mae Waltz

19a. Informant's Name/Relationship (Type, Print): Carrie Mae Crumbacker(wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2175 Dennings Rd. New Windsor, MD 21776

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation
Date: Feb. 6, 2001
20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: Todd J. Kelbaugh
22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. COPD — Approximate Interval: years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Herbert P. Henderson Jr. MD
29c. License number: D0051924
29d. Date signed (Month, Day, Year): February 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Herbert P. Henderson Jr. MD 295 Stoner Ave Suite 307, Westminster MD 21157

**State Registrar**

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Amended Items # 17 & 18, Per F.D. 02/07/2001, Carroll County, cew

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

1- For State Registrar

Reg. No. 2001 04956

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GLORIA CHRISTENSEN

2. Date of Death: Month 2 Day 5 Year 2001

3. Time of Death: 2053 M

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: Baltimore City

**Funeral Director**

5. Social Security Number: 145-16-8456

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 21, 1924

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: RI

10b. County: Newport

10c. City, Town or Location: Newport

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 49 Hillside Avenue

10f. Zip Code: 02840

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Clerical

17. Father's Name (First, Middle, Last): William Hicks ~~Unknown~~

18. Mother's Name (First, Middle, Maiden Surname): Mary Madeline Katon ~~Unknown~~

19a. Informant's Name/Reletionship (Type, Print): Ms. Tina L. Snyder (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12565 Indian Hill Dr., Sykesville, MD 21784

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): All County Cremation Srv. Date: 2/7/01

20c. Location - City or Town, Stete: Sykesville, MD

21. Signature of Funeral Service Licensee: Brian L. Haight

22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. METASTATIC ESOPHAGEAL CANCER

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: TAYLOR MD

29c. License number: P13997

29d. Date signed (Month, Day, Year): FEBRUARY 5 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michelle D. Taylor, M.D. 22 SOUTH GREENE STREET, BALTIMORE MD 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04957

CROPPER, MARY

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Mary Lynch Cropper
2. Date of Death (Month, Day, Year): FEBRUARY 6, 2001
3. Time of Death: 10:40 P.M.
4a. Facility Name (If not institution, give street and number): Berlin Nursing and Rehabilitation Center
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester
5. Social Security Number: 218-20-7243
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 1/26/1907
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Berlin
10d. Inside City Limits: XX 1☐ Yes 2☐ No
10e. Street and Number: 9715 Healthway Drive
10f. Zip Code: 21811
10g. Citizen of What Country: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Homemaker
17. Father's Name (First, Middle, Last): Henry Lee Lynch
18. Mother's Name (First, Middle, Maiden Surname): Katie Holland
19a. Informant's Name/Relationship (Type, Print): Franklin Lynch-Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 Kenwood Ct., Berlin, MD 21811
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Cemetery Date: 2/9/2001
20c. Location - City or Town, State: Berlin, MD 21811
21. Signature of Funeral Service Licensee: W. Eric Burbage
22. Name and Address of Facility: The Burbage Funeral Home 108 William Street Berlin, MD 21811

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) | a. Acute Cerebrovascular Acc. | 7 Days |
| Due to (or as a consequence of): | b. Arteriosclerosis - | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. | |
| Due to (or as a consequence of): | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Intermittent - Bladder Obstruction
R - H.p. Replacement.
L - Femoral Fx

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D02026
29d. Date signed (Month, Day, Year): 2-7-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD 21811

**State Registrar**

5

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrar's Signature: Louise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04958

Joyce Chandler

Baltimore, Maryland 21215-0020

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month Day Year) | 3. Time of Death |
|---|---|---|
| JOYCE RASHER CHANDLER | 01 30 2001 | 11:13PM |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Hartley Hall Nursing Home | Pocomoke City | Worcester |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Yeer) | 9. Birthplaca (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 117-26-6801 | 1☐ M 2☒ F | 70 Yrs. | | | 11/22/1930 | New York |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Worcester | Pocomoke City | 1☐ Yes 2☒ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 1006 Market Street | 21851 | USA |

| 11. Maritial Status | 12. Was Decedent Ever in U.S. Armad Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Year or Dates: | 1☐ Yes 2☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highast grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Waitress | Food Service |

| 17. Fether's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Surname) |
|---|---|
| Adolphus Valentine Rasher | Jennie Roselia Wile |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) |
|---|---|
| Robin Miles/ Daughter | 8385 Courthouse Hill, Rd Pocomoke City, MD 21851 |

| 20a. Method of Disposition | 20b. Place of Disposition (Neme of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) | Salisbury Crematory | 1/31/01 | Salisbury, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Michael A Dean M01129 | Holloway Melson Funeral Home, PA 103 Linden Ave. Pocomoke City, MD 21851 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Intervel Between Onset and Death |
|---|---|---|
| Immediate Cause (Final diseese or condition resulting in death) | Lewy Body Disease Dementia | 4 yrs |
| Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b. Due to (or as a consequence of): | | |
| c. Due to (or es e consequence of): | | |
| d. | | |

Part II. **Othar significant conditions** contributing to death but not resulting in tha underlying ceuse given in Part I.

Cerebrovascular Disease
Diabetes Mellitus Type II
Arteriosclerotic Cardiovascular Disease

23b. **Did tobacco uaa contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

| 24a. Was an autopsy performed? | 24b. Were eutopsy findings available prior to compiation of ceusa of death? |
|---|---|
| 1☐ Yes 2☒ No | 1☐ Yes 2☒ No |

| 25. Was cese referred to medicel examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☒ No | Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined | | M | 1☐ Yes 2☐ No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)

1☒ **Certifying Phyaicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Gregorio M. Belloso MD | D29505 | 1-31-01 |

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours efter death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Deperiment of Health end Mental Hygiene.

**Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

2

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signeture |
|---|---|
| FEB 01 2001 | G. Sparks |

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04959

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ruth Greer Colvard

2. Date of Death Month: February Day: 9 Year: 2001

3. Time of Death: 9:05 PM

4a. Facility Name *(If not institution, give street end number)*: Charlestown Retirement Community

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 238-58-4075

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 24, 1912

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 9530 Valleymede Ct.

10f. Zip Code: 21042

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: George Thomas Greer

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Hare

19a. Informant's Name/Relationship *(Type, Print)*: Ben H. Colvard III / son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 9530 Valleymede Ct. Ellicott City, MD. 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Lawn Cemetery

Date: Feb. 14 2001

20c. Location - City or Town, State: North Wilkesboro, N.C.

21. Signature of Funeral Service Licensee: [signature] M01092

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Profound Dementia — Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic UTI

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D26473

29d. Date signed *(Month, Day, Year)*: February 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bernard F Kozlovsky MD - 711 MAIDEN CHOICE LANE, BALTIMORE, MD 21228

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 12 2001

32. Registrar's Signature: [signature] D. Sparks

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04960

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Minnie Octavia Brown

2. Date of Death: Month February Day 6, Year 2001

3. Time of Death: 3:40 A.M.

4a. Facility Name (If not institution, give street and number): Calvert County Nursing Center

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

**Funeral Director**

5. Social Security Number: 213-38-1239

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 20, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Sunderland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6825 Kent Road

10f. Zip Code: 20689

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Everett Gross

18. Mother's Name (First, Middle, Maiden Surname): Eliza Dawkins

19a. Informant's Name/Relationship (Type, Print): Daniel Brown/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 440 Sunderland, MD 20689

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ward's UM Church Cem. | Date: 2/10/01

20c. Location - City or Town, State: Owings, MD

21. Signature of Funeral Service Licensee: ▶ Gladys A. Sewell

22. Name and Address of Facility: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute MI

Due to (or as a consequence of):
b. Complete Heart block

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. V. Tachycardia

Due to (or as a consequence of):
d. Urosepsis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ D. Shah

29c. License number: D 50290

29d. Date signed (Month, Day, Year): 2-7-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DHIREN SHAH . 110, HOSP RD, # 303 PRINCE FREDRICK MD 20678

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

5

**State Registrar**

31. Date filed (Month, Day, Year): FEB 07 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

8:55AM JANUARY 31, 2001 ANDREW CHERRICO

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04961

**Physician /Medical Examiner**

1. Decadant's Nama *(First, Middla, Last)*: ANDREW CHERRICO
2. Date of Death (Month, Dey, Yaar): January 31, 2001
3. Time of Death: 8:55 a.m.
4e. Facility Nema *(If not institution, give street and number)*: Charlotte Hall Veterans Home
4b. City, Town, or Location of Deeth: Charlotte Hall
4c. County of Death: St. Mary's

**Funeral Director**

5. Social Security Number: 578 07 2443
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Year)*: Nov. 11, 1915
9. Birthplece *(State or Foreign Country)*: Washington, DC

Usual Residence of Dacadent

10e. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Charlotte Hall
10d. Inside City Limits: 1☐Yes 2☒No
10a. Street end Number: 29449 Charlotte Hall Road
10f. Zip Code: 20622
10g. Citizen of What Country?: USA
11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Dacadent Ever in U,S. Armed Forces? 1☒Yes 2☐No — If Yes, Give Year or Dates: 1943 1945
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Race - American Indien, Black, White, atc. *Specify:* white
15. Decedent's Education *(Specify only highest grada completed)*: Elemantary/Secondary (0-12): 8; Collega (1-4or 5+):
16e. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa ratired)*: Baker
16b. Kind of Businass/Industry: Food
17. Father's Name *(First, Middle, Last)*: Ralph Cherrico
18. Mothar's Name *(First, Middle, Maiden Surname)*: Philomina Binnardo
19a. Informant's Nama/Ralationship *(Type, Print)*: Andrew Cherrico, Jr. / son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 3565 Garrett Lane, Huntingtown, MD 20639
20e. Mathod of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Nama of cemetery, crematory or other place)*: Maryland Veterans
Date: 2/6/01
20c. Location - City or Town, Stete: Cheltenham, MD
21. Signeture of Funeral Service Licensee: ▶ Charles F. Bell, Jr.
22. Neme end Address of Fecility: Rausch Funeral Home, P.A. P.O. Box 100, Owings, MD 20736

**Physician /Medical Examiner**

23a. Pert1. Enter the diseese, or complicetions that caused tha death. Do not enter tha mode of dying, such es cardiac or respiretory arrest, shock, or haart failure. List only one cause on eech lina.

Approximate Intervel Batween Onset end Deeth

Immediate Cause (Final diseasa or condition resulting in daath)
e. Cardiomyopathy. — more than 3 months

Due to (or es a consequanca of):
b. Atherosclerotic Cardiovascular disease — more than 1 year

Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disaesa or injury that initiatad evants resulting in death) Lest

Due to (or es a consequence of):
c.

Due to (or es a consequence of):
d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

Renal insufficiency
Dementia.

23b. Did tobacco use contribute to the cause of deeth? 1☐Yee 2☐No 3☐Probably 4☒Unknown

24a. Wes an eutopsy performed? 1☐Yes 2☒No

24b. Ware autopsy findings aveilable prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Piece of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Deeth: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Spacify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒**Certifying Phyeician:** To the bast of my knowladga, daath occurrad at tha tima, data and place, and due to the ceusa(s) and mannar as statad. 2☐**Medical Examiner:** On tha basis of examinetion end/or investigation, in my opinion, daath occurrad at the time, dete and placa, and dua to tha causa(s) and manner steted.

29b. Signeture end title of certifier: ▶ C.C. Surana
29c. License number: D. 50653
29d. Date signed *(Month, Day, Year)*: 1/31/01.

30. Name and eddress of person who complated cause of deeth (Item 23e) (Type, Print): GYAN. C. SURANA 5851- Deale Churchton Road. Deale MD 20751.

**State Registrar**

31. Deta filed *(Month, Day, Year)*
32. Registrar's Signeture: ▶

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04962

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Ruth Delph
2. Data of Daath (Month, Day, Year): February 2, 2001
3. Tima of Daath: 10:35am
4a. Facility Nama (If not institution, giva straat and number): Westminster Nursing Home
4b. City, Town, or Location of Daath: Westminster
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 218-74-8222
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 57 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Nov. 6, 1943
9. Birthplaca (State or Foraign Country): Virginia

Usual Rasidance of Decedant

10a. Stata: MD
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 1234 Washington Road
10f. Zip Coda: 21157
10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Raca - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedant's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): 4 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Laborer
16b. Kind of Business/Industry: Horse Farm

17. Fathar's Nama (First, Middla, Last): Adema Delph
18. Mothar's Nama (First, Middla, Maidan Sumama): Hazel B. Waddell

19a. Informant's Name/Ralationship (Type, Print): Ms. Reba Smith (Sister)
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 57½ King Street Littlestown, PA 17340

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar placa): All County Cremation Srv
Data: 2/3/01
20c. Location - City or Town, Stata: Sykesville, MD

21. Signature of Funaral Sarvica Licensee: ▶ Brian L. Haight
22. Nama and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after daath with the Maryland Department of Health and Mental Hygiena.
**Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart feilura. List only ona cause on each line.

| | | Approximate Intarval Batween Onsat and Death |
|---|---|---|
| Immadiata Causa (Final disaasa or condition rasulting in daath) a. | End Stage Diabetes | 30yr |
| Dua to (or as a consequance of): b. | ASCVD | 20yr |
| Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last — Dua to (or as a consaquanca of): c. | Renal failure | 1yr |
| Dua to (or as a consequanca of): d. | Severe PVD | 5yr |

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to compiation of cause of daath? 1☐ Yas 2☐ No

25. Was case referrad to medical examinar? 1☐ Yas 2☒ No

26. Place of Daath (Check only ona) — Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, death occurrad at tha tima, data and place, and dua to tha cause(s) and mannar statad.

29b. Signature and title of certifiar: ▶ John Middleton
29c. Licensa number: D25443
29d. Data signed (Month, Day, Year): 2-2-2001

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): John W. Middleton 688 Poole Rd, Westminster, Md 21157

**To the Hospital or Attending Physician:** The law requiras that tha daath certificata be executed within 24 hours after daath.
**To the Funeral Director:** After this certificata has been signed by tha attanding physician and completely filled in by tha funaral director, page 2 should be detached for usa as tha burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

31. Data filed (Month, Day, Year): FEB 06 2001
32. Registrar's Signatura: Jennie G Sparks

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 04963

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Lois May Davis

2. Date of Death (Month, Day, Year): February 9, 2001

3. Time of Death: 8:20 am

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 217-32-2423

6. Sex: 1☐ M 2☒ F (XX)

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 5, 1910

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No (XX)

10e. Street and Number: 2330 Briggs Chaney Road

10f. Zip Code: 20905

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 2 Years College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Montgomery County School System

17. Father's Name (First, Middle, Last): Berkeley Wilson

18. Mother's Name (First, Middle, Maiden Surname): Susan H. Carter

19a. Informant's Name/Relationship (Type, Print): Berkeley Davis / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2340 Briggs Chaney Road Silver Spring, Md. 20905

20a. Method of Disposition: 1XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Union Cemetery

Date: Feb 13, 2001

20c. Location - City or Town, State: Burtonsville, Md.

21. Signature of Funeral Service Licensee: ▶ [signature] /M00770

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Urinary tract infection

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dehydration.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residanca 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D0043351

29d. Date signed (Month, Day, Year): 2/9/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 6201 Greenbelt Rd Suite 4-15 College PK MD 20740

**State Registrar**

31. Date filed (Month, Day, Year): FEB 12 2001

32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04964

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: BETTYANN DIX

2. Date of Death Month / Dey / Yeer: FEBRUARY 7 2001

3. Time of Death: 7:30 PM

4a. Facility Name *(If not institution, give street and number)*: Fort Washington Medical Center

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince Georg's

**Funeral Director**

5. Social Security Number: 497 26 8692

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 23 1929

9. Birthplace *(State or Foreign Country)*: Colorado

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2409 Porter Avenue

10f. Zip Code: 20746

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Fether's Name *(First, Middle, Last)*: Clyde Dusenberry

18. Mother's Neme *(First, Middle, Maiden Surname)*: Minnie Belle Dusenberry

19a. Informant's Neme/Relationship *(Type, Print)*: John A. Dix Jr

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6303 Hellen Lee Drive Clinton, MD 20735

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☑ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Washington Nat'l Cem

Dete: 2-10-01

20c. Locetion - Clty or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: John A Dix M00173

22. Name and Address of Facility: Eberwein Funeral Services 4433 White Pls. La. White Pls., MD 20695

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Meryland Department of Health end Mental Hygiene.

**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth): e. Metastatic Carcinoma

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Chronic Obstructive lung disease

Chronic pancreatitis

23b. Did tobacco uae contribute to tha cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours efter death.

**To the Funeral Director:** After this certificate has been signed by the attending physician end completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture and title of certifier: M.D

29c. License number: MD D24020

29d. Date signed *(Month, Day, Year)*: 2/8/01

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print): MOTI L KOUL M.D 4467 old Branch Ave Temple Hills md

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 09 2001

32. Registrar's Signeture: Jenna G. Sparks

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04965

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: DOROTHY ELLIOTT
2. Date of Death Month / Day / Year: February 2, 2001
3. Time of Death: 18:55
4a. Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

**Funeral Director**

5. Social Security Number: 219 58 9962
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec 25 1932
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Broomes Island
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8841 Broomes Island Road
10f. Zip Code: 20615
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: secretary
16b. Kind of Business/Industry: St. Mary's Co. School

17. Father's Name *(First, Middle, Last)*: John Douglas Ramsey
18. Mother's Name *(First, Middle, Maiden Surname)*: Nellie Hooper

19a. Informant's Name/Relationship *(Type, Print)*: Brice L. Elliott, Sr. -spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8841 Broomes Is Rd. Broomes Island Md. 20615

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Asbury Cemetery — Date: Feb 7, 2001
20c. Location - City or Town, State: Barstow Maryland

21. Signature of Funeral Service Licensee: ▶ JB Rausch
22. Name and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Sudden cardiac death. — minutes

Due to (or as a consequence of):
b. possibly pulmonary embolus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
lithium toxicity
Chronic lymphocytic leukemia
coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶
29c. License number: D43306
29d. Date signed *(Month, Day, Year)*: 2/2/01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Sylvia Batong, MD 11845 H.G. Trueman Rd., Lusby, MD 20657

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 05 2001
32. Registrar's Signature: ▶ Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04966

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: FRANCES EDMONSTON

2. Date of Death Month: Feb Day: 10 Year: 2001

3. Time of Death: 21:47

4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 219-05-5640

6. Sex: 1☐ M 2☒ F XX

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb 24, 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Howard

10c. City, Town or Location: Dayton

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 5315 Greenbridge Road

10f. Zip Code: 21036-1201

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No X
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.)
1☐ Yes 2☐ No XX *Specify:*

14. Race - American Indian, Black, White, etc.
*Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): Grade 12
College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bank Teller/Auditor

16b. Kind of Business/Industry: Banking

17. Father's Name *(First, Middle, Last)*: Michael Kraeski

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Selway

19a. Informant's Name/Relationship *(Type, Print)*: James O. Edmonston / spouse

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5315 Greenbridge Road Dayton, Maryland 21036

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)* X

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Mary's Cemetery

Date: Feb. 14, 2001

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Gary S. Kyer /M00770

22. Name and Address of Facility: Donaldson Funeral Home, P.A.
313 Talbott Avenue Laurel, Maryland 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Atherosclerotic Cardiovascular Disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patryce A. Toye MD Deputy MD

29c. License number: D31473

29d. Date signed *(Month, Day, Year)*: Feb 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRYCE A. TOYE, MD 4565 Hemlock Cone Way Ellicott City MD

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 12 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04967

amend item #17 per f.h., 2/9/01,bg

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William Ballard Fontaine

2. Date of Death: Month: February Day: 7 Year: 2001

3. Time of Death: 2200

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 230-18-5337

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 05/05/1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Somerset

10c. City, Town or Location: Westover

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9188 Fontaine Road

10f. Zip Code: 21871

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): William ~~Ward~~ Wade Fontaine

18. Mother's Name (First, Middle, Maiden Surname): Anna Rose Fontaine

19a. Informant's Name/Relationship (Type, Print): daughter Ann Copper Fontaine Lewis /

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Fontaine Road, Westover, Md. 21871

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Manokin Presbyterian Cem.

Date: 2/10/01

20c. Location - City or Town, State: Princess Anne, Md.

21. Signature of Funeral Service Licensee: James L. Hinman MO0295

22. Name and Address of Facility: Hinman Funeral Home 11673 Somerset Ave., Princess Anne, Md. 21853

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Tachy-brady dysrhythmia, atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles Stegman MD

29c. License number: D25219

29d. Date signed (Month, Day, Year): 2-8-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles Stegman, Mt. Vernon Rd, Princess Anne, MD 21853

**State Registrar**

31. Date filed (Month, Day, Year): FEB 09 2001

32. Registrar's Signature: Geneva G. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WILLIAM FONTAINE SS#230-18-5337 2/7/01 2458 8/40

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04968

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ELLA GROOMES

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ella Mae Groomes

2. Date of Death (Month, Day, Year): Feb 1, 2001

3. Time of Death: 2020

4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 219-10-6017

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 23, 1915

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Hampstead

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 4242 Upper Beckleysville Rd

10f. Zip Code: 21074

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employed

16b. Kind of Business/Industry: Dairy Farmer

17. Father's Name *(First, Middle, Last)*: Raymond Thomas Meekins

18. Mother's Name *(First, Middle, Maiden Surname)*: Maggie Smoot

19a. Informant's Name/Relationship *(Type, Print)*: Rebecca Krumrine, granddaughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4909 Oriole Ct, Westminster, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Evergreen Memorial Gard

Date: 02/05/2001

20c. Location - City or Town, State: Finksburg, MD

21. Signature of Funeral Service Licensee: Steven W Eline M00723

22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Ruptured abdominal aortic aneurysm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Myocardial infarction

Due to (or as a consequence of):

c. Acute CVA

Due to (or as a consequence of):

d. Acute Renal failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Disseminated intravascular coagulation.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D51072

29d. Date signed *(Month, Day, Year)*: 2/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sharon Taylor-Hollinan, Carroll County General Hospital, 200 Memorial Ave. Westminster, MD 21157

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 06 2001

32. Registrar's Signature: Donna G Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black indelible ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04969

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Aulda Beulah Green
2. Date of Death (Month, Day, Year): February 4 2001
3. Time of Death: 12:30pm
4a. Facility Name *(If not institution, give street and number)*: 7708 Carter Road
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 233-64-5686
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb 23 1919
9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: Md
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7708 Carter Road
10f. Zip Code: 21784
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker
16b. Kind of Business/Industry: domestic
17. Father's Name *(First, Middle, Last)*: Frank Mathes
18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah Keller
19a. Informant's Name/Relationship *(Type, Print)*: Shirley Cool (daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 409 Ross Dr. Sykesville, Md 21784
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crest Lawn Memorial | Date: 2-8-2001
20c. Location - City or Town, State: Marriottsville, Md
21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert
22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md 21784

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Severe Emphysema/COPD — 10 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but *not* resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] INTERNIST, MD
29c. License number: D 52035
29d. Date signed *(Month, Day, Year)*: Feb 6 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BINU CHACKO, 291 Stoner Avenue, Dixon Building Westminister MD 21157

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 07 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

MARY GROFF
B.K.S

01-0620-045 1- For State Registrar

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

2001 04970
Reg. No.

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | | | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|---|---|
| MARY | JANE | GROFF | FEB 4, 2001 | 7:02 P M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| PENINSULA REGIONAL MEDICAL CENTER | SALISBURY | WICOMICO |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-40-6327 | 1☐M 2☒F | 59 Yrs. | | | 10/6/1941 | Maryland |

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Worcester | Pocomoke City | 1☐Yes 2☒No |

| 10e. Street end Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 1730 Buck Harbor Road | 21851 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Bleck, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No It Yes, Give Year or Detes: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | 18b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 12 | | Manager | Banking |

| 17. Father's Neme (First, Middle, Last) | 18. Mother's Name (First, Middle, Meiden Sumeme) |
|---|---|
| Herman V. Trader, Sr. | Elaine K. Hart |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ron Groff (husband) | 1730 Buck Harbor Road., Pocomoke City, MD 21851 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) | Dete | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Buriel 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Remson United Methodist Cemetery | 2/7/2001 | Pocomoke City, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| ▶ Michael A Dean mo1129 | Holloway Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851 |

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other then "natural", or items 23e or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert failure. List only one cause on eech line.

| | | Approximete Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Finel disease or condition resulting in deeth) | a. CHEST INJURIES | |
| Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last | b. Due to (or as e consequence of): | |
| | c. Due to (or as e consequence of): | |
| | d. Due to (or as e consequence of): | |

| IF FEMALE: 23b. Wes decedent pregnent in the pest 12 months? | 23c. If yes, outcome of pregnancy | 23d. Dete ot delivery Month Day Year |
|---|---|---|
| 1☐Yes 2☒No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnency 4☐Pregnent et time of deeth 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contnbuting to death but not resulting in the underlying ceuse given in Part I.

| 23e. Did tobecco use contnbute to the cause of death? | 24e. Wes en eutopsy performed? | 24b. Were eutopsy findings evailable prior to completion ot ceuse ot death? |
|---|---|---|
| 1☐Yes 2☒No 3☐Probably 4☐Unknown | 1☒Yes 2☐No | 1☒Yes 2☐No |

**Medical Certification: To Be Completed by Physician/Medical Examiner**

| 25. Wes case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Menner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined | 2-4-01 | ~ 18:30 P M | 1☐Yes 2☒No | PASSENGER IN CAR, IMPACT WITH FIXED OBJECT |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rural Route Number, City or Town, State) |
|---|---|
| ROADWAY | RT 13 POCOMOKE - SOMERSET CO, MD |

| 29a. Certifier (Check only one) | |
|---|---|
| 1☐ | **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner es stated. |
| 2☒ | **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) and manner stated. |

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Dey, Yeer) |
|---|---|---|
| ▶ Maryanne Mitchell MD | O.C.M.E | FEB. 5, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARYANNE A. KOROW 111 Penn Street, Baltimore, Maryland 21201

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

15

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 08 2001 | G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04971

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): EVELYN MARIE GUM
2. Date of Death (Month, Day, Year): FEBRUARY 04 2001
3. Time of Death: 8:04 AM
4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF FOREST HILL
4b. City, Town, or Location of Death: FOREST HILL
4c. County of Death: HARFORD

**Funeral Director**

5. Social Security Number: 219-18-6738
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 8, 1924
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1777 Blue Ball Road
10f. Zip Code: 21921
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager
16b. Kind of Business/Industry: Credit Bureau

17. Father's Neme (First, Middle, Last): James Blaine Long
18. Mother's Name (First, Middle, Maiden Surneme): Mary M. Carr

19a. Informant's Name/Relationship (Type, Print): Kevin B. Gum (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1303 Breezeway Dr. Annapolis, MD 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Bel Air Memorial Gdns.
Date: 2/8/01
20c. Location - City or Town, State: Bel Air, MD

21. Signature of Funeral Service Licensee: ▶ Frank S Zeller II
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in deeth)
a. pneumonia atelectasis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
diabetes
hypertheyroid
peripheral vascular disease

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ David S. Dunn
29c. License number: D32293
29d. Date signed (Month, Day, Year): February 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID S DUNN 615 W. MacPhail

**State Registrar**

31. Date filed (Month, Day, Year): FEB 6 2001
32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04972

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Almon A. Gray, Jr.

2. Date of Death (Month, Day, Year): February 13, 2001

3. Time of Death: 2:31pm

4e. Facility Name *(If not institution, give street and number)*: 9413 Van Buren Street

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

**Funeral Director**

5. Social Security Number: 225-46-2512

6. Sex: 1 XX M 2 ☐ F

7. Age *(In yrs. last birthday)*: 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 5, 1938

9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1 ☐ Yes 2 XX No

10e. Street and Number: 9413 Van Buren Street

10f. Zip Code: 20706

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 4 years

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer

16b. Kind of Business/Industry: NASA

17. Father's Name *(First, Middle, Last)*: Almon Gray, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Evelyn Brown

19a. Informant's Name/Relationship *(Type, Print)*: Gail Rosenzweig / sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8702 Crystal Rock Lane Laurel, Maryland 20708

20a. Method of Disposition: 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.

Date: Feb 14 2001

20c. Location - City or Town, State: Catonsville, Md.

21. Signature of Funeral Service Licensee: [signature] /M00770

22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio Respiratory failure — minutes

Due to (or as a consequence of):

b. Myocardial Infarction — minutes

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ **Yes** 2 ☐ **No** 3 ☐ **Probably** 4 X **Unknown**

24a. Was an autopsy performed? 1 ☐ Yes 2 XX No

24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 XX No

**Medical Certification: To Be Completed by Physician/Medical Examiner**

25. Was case referred to medical examiner? 1 XX Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 X **Certifying Phyalcian**: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D0042552

29d. Date signed *(Month, Day, Year)*: Feb. 14. 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 5530 Wisconsin Avenue Suite 715 Chevy Chase, Maryland

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 15 2001

32. Registrar's Signature: [signature] D. Sparks

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25

CGJ

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04973

Richmond Hayman

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death (Month / Day / Year) | 3. Time of Death |
|---|---|---|
| MILLARD RICHMOND HAYMAN | 02 / 07 / 2001 | 7:40 am |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Hartley Hall Nursing Home | Pocomoke City | Worcester |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-14-4745 | 1 ☒ M 2 ☐ F | 83 Yrs. | | | 6/13/1917 | Maryland |

Usual Residence of Decadent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Worcester | Pocomoke City | 1 ☒ Yes 2 ☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 403 Second Street | 21851 | USA |

| 11. Marital Status | 12. Was Decadent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: | 1 ☐ Yes 2 ☒ No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 11 | | Clerk | Retail |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Millard James Hayman | Viola Frances Merritt |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Willard Richardson (cousin) | 5248 Onley Rd., Girdletree, MD 21829 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetary, cramatory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Bethany United Methodist Cemetery | 2/9/2001 | Pocomoke City, MD |

| 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility |
|---|---|
| Michael B Dean mo1129 | Holloway Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Ceuse (Final disease or condition resulting in death) | e. Cardiomyopathy | 5 yrs |
| Due to (or as a consequence of): | b. Arteriosclerotic Cardiovascular Disease | 5 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): | c. | |
| Due to (or as a consequence of): | d. | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CVA with Right Hemiplegia
Chronic Obstructive Pulmonary Disease
Carcinoma of Prostate. Gastritis. Anemia

| 23b. Did tobacco use contribute to the cause of death? | 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of cause of death? |
|---|---|---|
| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown | 1 ☐ Yes 2 ☒ No | 1 ☐ Yes 2 ☒ No |

| 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1 ☐ Yes 2 ☒ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. Manner of Death | 28e. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ Yes 2 ☐ No | |
| | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |

| 29a. Certifier (Check only one) | |
|---|---|
| 1 ☒ | **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. |
| 2 ☐ | **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner steted. |

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| Gregorio A. Belloso M.D. | D 29505 | 2-7-2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 21801

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 08 2001 | Geneva G. Sparks |

DHMH 16 Rev 6/95

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04974

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Ethel M. Hovermale
2. Date of Death: Month 01 Dey 30 Yeer 2001
3. Time of Death: 2:20 PM
4a. Facility Name (If not institution, give street and number): Shore Nursing & Rehab Ctr
4b. City, Town, or Location of Death: DENTON
4c. County of Death: CAROLINE

**Funeral Director**

5. Social Security Number: 224-62-9905
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Mar. 1, 1902
9. Birthplece (Stete or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Caroline
10c. City, Town or Location: Denton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 420 Colonial Dr.
10f. Zip Code: 21629
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Eduction (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Homemaking

17. Father's Name (First, Middle, Last): Newton L. Hottle
18. Mother's Name (First, Middle, Maiden Surneme): Effie V. Jolly

19a. Informent's Neme/Relationship (Type, Print): K. W. Hovermale, Jr. Grand Son
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): P.O. Box 578, Portland, ME 04112-0578

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Cape Charles Cemetery
Date: 2/2/01
20c. Location - City or Town, State: Cape Charles, Va.

21. Signeture of Funerel Service Licensee: Henry Wilkins
22. Name and Address of Fecility: Wilkins-Doughty Funeral Home 119 Pine St., Cape Charles, Va.

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heart teilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death): a. Pneumonia — 1wk

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia
Depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end piece, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: [signature]
29c. License number: D32036
29d. Date signed (Month, Dey, Yeer): 01/30/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Gary F. Sprane 2107 P. Dorah Drive Chester, MD 21619

**State Registrar**

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04975

Mable Holden

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2+1

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Mable M. Holden
2. Date of Death (Month, Day, Year): February 05, 2001
3. Time of Death: 6 PM
4a. Facility Name (If not institution, give street and number): Manokin Manor
4b. City, Town, or Location of Death: Princess Anne
4c. County of Death: Somerset
5. Social Security Number: 219-14-3687
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-18-24
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: Worcester
10c. City, Town or Location: Pocomoke
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 809 Cedar Street
10f. Zip Code: 21851
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Production Worker
16b. Kind of Business/Industry: Campbell Soup Co.

17. Father's Name (First, Middle, Last): Bernard Waters
18. Mother's Name (First, Middle, Maiden Surname): Mable Jester

19a. Informant's Name/Relationship (Type, Print): Marlene Harmon (daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 809 Cedar Street Pocomoke Md. 21851

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): John Wesley Cemetary
Date: 2-10-01
20c. Location - City or Town, State: Westover, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bennie Smith Funeral Home P.O. Box 331 Pocomoke Md. 21851

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. esophageal cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. COPD
Due to (or as a consequence of):
c. Pneumonia
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] N Allen
29c. License number: D 47094
29d. Date signed (Month, Day, Year): 2/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NATHAN 106 PINE BLUFF ROAD SALISBURY MD 21801

**State Registrar**

31. Date filed (Month, Day, Year): FEB 08 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No: 2001 04976

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Viance Holden

2. Date of Death (Month, Day, Year): JANUARY 27, 2001

3. Time of Death: 1728

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 229-38-9969

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8-11-35

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Pocomoke City

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 1210 Newtown Apts

10f. Zip Code: 21851

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Production/Line Worker

16b. Kind of Business/Industry: Seafood Industry

17. Father's Name (First, Middle, Last): Everret Holden

18. Mother's Name (First, Middle, Maiden Surname): Jennister Dennis

19a. Informant's Name/Relationship (Type, Print): Delia Trader/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 53 Withams, Virginia 23488

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Groton's Cemetery

Date: 02/03/01

20c. Location - City or Town, State: Massongo, Virginia

21. Signature of Funeral Service Licensee: Russell Ford

22. Name and Address of Facility: Bennie Smith Funeral Homes P.O. Box 331 Pocomoke City, Maryland 21851

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiretory arrast, shock, or heart tailure. List only ona causa on aach lina.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disaasa or condition rasulting in death)

a. Ventricular fibrillation — minutes

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cormary artery disease — years

Due to (or as a consequance of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yas 2☒ No

24b. Wera autopsy findings available prior to complation of cause of daath? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and placa, and due to the cause(s) and menner stetad.

29b. Signature and title of certifier: Stephan Pavlos MD

29c. License number: D41721

29d. Date signed (Month, Day, Year): 01/29/01

30. Nama and address of person who compieted cause of daath (Item 23a) (Type, Print): Stephan Pavlos MD 400 E. Isdore Dr. Salisbury MD 21804

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

229-38-9969 VIANCES HOLDEN

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04977

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): VENDITA HANSEN
2. Date of Death: Month FEB. Day 7 Year 2001
3. Time of Death: 5:00 AM
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 213-34-7023
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 1, 1915
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md.
10b. County: Howard
10c. City, Town or Location: Fulton
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 8207 Reservoir Road
10f. Zip Code: 20759
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No XX If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No XX Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Co-Owner
16b. Kind of Business/Industry: Gift Shop

17. Father's Name (First, Middle, Last): George Patton Morell
18. Mother's Name (First, Middle, Maiden Surname): Bessie Gardner

19a. Informent's Name/Relationship (Type, Print): Wilbur Hansen / spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8207 Reservoir Road Fulton, Maryland 20759

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Hill Cemetery | Date: Feb 13, 2001
20c. Location - City or Town, State: Kingsport, Tenn.

21. Signature of Funeral Service Licensee: Gary S. Kyer / M00770
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | PNEUMONIA | 3 WEEKS |
| Due to (or as a consequence of): b. | ILEUS | 4 WEEKS |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | CHOLECYSTITIS | 6 WEEKS |
| Due to (or as a consequence of): d. | CHOLEDOCHOLITHIASIS | 6 WEEKS |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

CHRONIC CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Maurer MD
29c. License number: D29909
29d. Date signed (Month, Day, Year): FEB. 7 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. MAURER 2465 ROUTE 97 GLENWOOD MD 21738

**State Registrar**

31. Date filed (Month, Day, Year): FEB 12 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036**

**To Be Completed by Funeral Director**

(29)

01-0628-017
CJ
Corrine Taylor James

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM 23a,27 per ME G794 040201 SS

# Certificate of Death

Reg. No. 2001 04978

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month / Day / Year | 3. Time of Death |
|---|---|---|
| Corrine Taylor James | February 05 2001 | 12:15 P.M |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| Civista Medical Center | LaPlata | Charles |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-59-9005 | 1☐M 2☒F | 2 Months Yrs. | | | November 11, 2000 | Maryland |

**To Be Completed by Funeral Director**

Usual Residence of Decedent

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Charles | White Plains | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 10608 Jacksonhole Place | 20695 | USA |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| 0 | | Infant | Infant |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| Richard Curtis James | Jennifer Beth Moeller James |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Richard James/Father | 10608 Jacksonhole Pl. White Plains,MD 20695 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | St. Ignatius | 2/9/01 | Port Tobacco,MD. |

21. Signature of Funeral Service Licensee: David C. Echols M00945

22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD. 20646

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SUDDEN INFANT DEATH SYNDROME

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregnancy | 23d. Date of delivery Month / Day / Year |
|---|---|---|
| 1☐Yes 2☐No 9☐Unknown | 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown | |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

| 24a. Was an autopsy performed? | 24b. Were autopsy findings available prior to completion of ceuse of death? |
|---|---|
| 1☒Yes 2☐No | 1☒Yes 2☐No |

| 25. Was case referred to medical examiner? | 28. Place of Death (Check only one) | |
|---|---|---|
| 1☒Yes 2☐No | Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) |

| 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined | | M | 1☐Yes 2☐No | |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| M.D. | O.C.M.E. | February 6, 2001 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary G. Ripple M.D. 111 Penn Street, Baltimore, Maryland 21201

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

**State Registrar**

| 31. Date filed (Month, Day, Year) | 32. Registrar's Signature |
|---|---|
| FEB 08 2001 | Penny G. Sparks |

DHMH 17 Rev 1/2001

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04979

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Helen B. Koenig

2. Date of Death: Month: Feb; Day: 04; Year: 2001

3. Time of Death: 0845

4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

**Funeral Director**

5. Social Security Number: 054-07-5382

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 11, 1918

9. Birthplace (State or Foreign Country): New York

**To Be Completed by Funeral Director**

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4423 Keenan Drive

10f. Zip Code: 21042

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Social Security

17. Father's Name (First, Middle, Last): Boleslaw Gryniewski

18. Mother's Name (First, Middle, Maiden Surname): Emelia Meilko

19a. Informant's Name/Relationship (Type, Print): Mrs. Elizabeth K. Cvach (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4008 Moravia Road, Baltimore, MD 21206

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify): Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Maus.

Date: 2/8/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian A. Willen

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

**Physician /Medical Examiner**

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| Immediate Cause (Final disease or condition resulting in death) a. | Sepsis | 5 days |
| Due to (or as a consequence of): b. | Perforated Viscus | 2 weeks |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c. | Bowel Ischemia | several Months |
| Due to (or as a consequence of): d. | Atrial Fibrillation | several years |

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Parkinsons Disease

Hypertension

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jack E. Lewis, MD

29c. License number: D0056269

29d. Date signed (Month, Day, Year): Feb 04, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK E. LEWIS, MD, Good Samaritan Hospital 3601 Loch Raven Blvd Baltimore, MD 21239

**State Registrar**

31. Date filed (Month, Day, Year): FEB 6 2001

32. Registrar's Signature: Denise B. Sparks

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

12

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04980

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): William Thomas Krick
2. Date of Death: Month Feb Day 2, Year 2001
3. Time of Death: 533 PM
4a. Facility Name (If not institution, give street and number): Heritage Harbor
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 216 44 8967
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 30 1909
9. Birthplace (State or Foreign Country): Indiana

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Prince FRederick
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street end Number: 412 Park Terrace 4
10f. Zip Coda: 20678
10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yaer or Detes: 34-54
13. Wes Decedent of Hispenic Origin? (Specity Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired): communications
16b. Kind of Business/Industry: US Government
17. Father's Neme (First, Middle, Last): William E. Krick
18. Mother's Neme (First, Middle, Maiden Surneme): Mazie Wiltfong
19a. Informent's Neme/Relationship (Type, Print): Jan Messick POA/Executor
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): P.O. Box 403 Prince Frederick MD 20678
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify)
20b. Place of Disposition (Neme of cemetary, crametory or other place): Metropolitan Funeral Service | Dete: Feb 3, 2001
20c. Location - City or Town, Stete: Alexandria Virginia
21. Signeture of Funerel Service Licensee: BRausch
22. Name end Address of Fecility: Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 2067

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications thet caused the daeth. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one ceusa on eech line. | Approximete Intarvel Batween Onset end Death

Immediete Ceuse (Final disease or condition resulting in deeth)
e. Chronic Obstructive Pulmonary Disease
Dua to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disaese or Injury thet initieted events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
hypertension
Abdominal Aortic Aneurysm

23b. Did tobecco uee contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yas 2 ☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Piece of Death (Chack only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Panding investigetion 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Dascribe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end manner es stated. 2 ☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, daath occurred et the time, date end place, and dua to tha causa(s) and manner steted.
29b. Signeture and title of certifier
29c. Licensa number: Doo56420
29d. Data signad (Month, Dey, Year): Feb 2 2001
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Peter Wagner, MD 4203 Queensbury Rd. Hyattsville MD 20781

**State Registrar**

31. Data filed (Month, Day, Year): FEB 03 2001
32. Registrer's Signeture: Regina D Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

4 + 1 graft

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04981

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Samuel Cleveland Laub, Jr.

2. Date of Death Month Day Year: 2/7/2001

3. Time of Death: 1:14 AM

4a. Facility Name *(If not institution, give street end number)*: 102 Woodland Ct.

4b. City, Town, or Location of Death: Snow Hill

4c. County of Death: Worcester

**Funeral Director**

5. Social Security Number: 218-36-5093

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: 10/18/1939

9. Birthplece *(State or Foreign Country)*: LA

Usual Residence of Decedent

10a. Stata: MD

10b. County: Worcester

10c. City, Town or Location: Snow Hill

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 102 Woodland Ct.

10f. Zip Code: 21863

10g. Citizen of Whet Country?: USA

11. Merital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedent'a Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 5+

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrator

16b. Kind of Business/Industry: Nursing Home

17. Father's Name *(First, Middle, Last)*: Samuel Cleveland Laub, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Edna May

19a. Informant's Name/Relationship *(Type, Print)*: Gayle Copple Laub-wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 102 Woodland Ct., Snow Hill, MD 21863

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cape Henlopen Crematory

Date: 2/7/01

20c. Location - City or Town, State: Frankford, DE

21. Signature of Funeral Service Licensee: W. Fisk Burbage

22. Name end Address of Facility: The Burbage Funeral Home 108 William Street Berlin, MD 21811

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death)

a. Metastatic Renal Cell Cancer — 4 mo

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____

Due to (or es e consequence of):

c. ____

Due to (or as a consequenca of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joe Jarmo MD

29c. License number: D 20507

29d. Date signed *(Month, Day, Year)*: 2/7/01

15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph A. Grosso 145 E. Carroll St Salisbury MD

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 08 2001

32. Registrar's Signature: Benjamin D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04982

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Ruth E.S. Lyles

2. Date of Death (Month, Day, Year): February 4, 2001

3. Time of Death: 7:20AM

4a. Facility Name *(If not institution, give street and number)*: 7589 Newman Drive

4b. City, Town, or Location of Death: Charlotte HAll

4c. County of Death: Charles

**Funeral Director**

5. Social Security Number: 219-32-4243

6. Sex: 1☐ M XXX 2☐ F

7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: December 20,191

9. Birthplace *(State or Foreign Country)*: 1 Maryland

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Charles | 10c. City, Town or Location: Charlotte Hall | 10d. Inside City Limits: XX 1☐ Yas 2☐ No

10e. Street and Number: 7589 Newman Drive | 10f. Zip Code: 20622 | 10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Seamstress

17. Fathar's Nama *(First, Middle, Last)*: Samuel R. Thomas

18. Mother's Name *(First, Middle, Maiden Surnama)*: Viola Wills

19a. Informent's Name/Relationship *(Type, Print)*: Elaine Jones / Daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 7564 Newman Dr. Charlotte Hall,MD 20622

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Nama of cematary, crematory or othar place)*: St.Marys Cath.CH | Date: 2/9/01

20c. Location - City or Town, State: Bryantown Maryland

21. Signature of Funeral Service Licensee: Lloyd S

22. Name and Address of Facility: M0191 Adams Funeral Home P.A.Aquasco MD 20608

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Intervel Between Onset end Death

Immediata Cause (Final disaasa or condition resulting in daath)
e. Breast Cancer with metatasis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated evants resulting in death) Last
b.

Due to (or as a consequence of):
c.

Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes XXX No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ XXX

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home XX 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1 XXX Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Invastigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Routa Numbar, City or Town, Stata)*

29a. Certifier *(Check only one)*: XXX 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Krishan M. Mathur

29c. License number: D28352

29d. Dete signed *(Month, Day, Year)*: February 5,,2001

30. Name and address of person who compiatad causa of daath (Item 23a) (Type, Print): Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 0 8 2001

32. Registrar's Signature: Jenine G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04983

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): MARY LONG
2. Data of Death Month Dey Yaer: JANUARY 31, 2001
3. Tima of Death: 18:50
4a Facility Nama (If not institution, giva street and number): Calvert Memorial Hospital
4b. City, Town, or Location of Deeth: Prince Frederick
4c. County of Death: Calvert

**Funeral Director**

5. Social Sacurity Number: 215-54-8602
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 88 Yrs. — If Under 1 Yaer: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): May 29, 1912
9. Birthplace (Stata or Foraign Country): Maryland

Usual Rasidence of Decedant

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Port Republic
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 3005 Parkers Creek Road
10f. Zip Coda: 20676
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yas, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highest grada complatad): Elamentary/Secondary (0-12): 3 — Collaga (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired): Housewife
16b. Kind of Business/Industry: Own Home

17. Fathar's Name (First, Middle, Last): Warren Brown
18. Mothar's Nama (First, Middle, Maiden Surnama): Estelle Chase

19a. Informant's Name/Ralationship (Type, Print): Goldie Hawkins/Daughter
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): P.O. Box 844 Prince Frederick, MD 20678

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Patuxent UMC Cemetery
Date: 2/3/01
20c. Location - City or Town, Stata: Huntingtown, MD

21. Signature of Funeral Service Licensae: Blake A. Sewell
22. Name and Address of Facility: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that causad the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart feilura. List only ona causa on each line.

Approximata Intervel Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. pneumonia — 5days
Dua to (or as a consaquance of):

Sequantially list conditions, if any, laading to immediata causa. Enter Underlying Causa (Disease or Injury that initieted events resulting in daath) Last:
b. Dua to (or as a consequanca of):
c. Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.: osteoporosis, laryngeal cancer

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Ware autopsy findings availeble prior to completion of cause of deeth? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Place of Death (Check only ona)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Othar: 4☐ Nursing Hama 5☐ Residence 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Plece of Injury - At home, farm, straat, factory, office building, etc. (Specify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, data and place, and due to tha causa(s) and mannar as stated.
2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and titia of certifiar
29c. Licansa number: A39522
29d. Data signed (Month, Day, Year): 2/1/01

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): DR. JONATHAN FEARS, MD PRINCE FREDERICK MD 20678

**State Registrar**

31. Data filed (Month, Dey, Year): FEB 02 2001
32. Registrar's Signatura: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04984

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Peter William LaCroix
2. Date of Death (Month, Day, Year): Jan 31, 2001
3. Time of Death: 9 AM
4a. Facility Name (If not institution, give street and number): Solomons Nursing Center
4b. City, Town, or Location of Death: Solomons
4c. County of Death: Calvert

**Funeral Director**

5. Social Security Number: 548 36 5312
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 16 1929
9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: St. Leonard
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7109 Marshall Road
10f. Zip Code: 20685
10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Michigan State Police
16b. Kind of Business/Industry: law enforcement

17. Father's Name (First, Middle, Last): Richard Walter LaCroix
18. Mother's Name (First, Middle, Maiden Surname): Mabel C. Morrow

19a. Informant's Name/Relationship (Type, Print): Michelle LaCroix- daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 79 St. Leonard, MD 20685

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Funeral Service | Date: Feb 1, 2001
20c. Location - City or Town, State: AlexaNDRIA Virginia

21. Signature of Funeral Service Licensee: ▶ BRausch
22. Name and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. rd. Port Republic MD 20676

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Dementia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Hemorrhagic Stroke
Due to (or as a consequence of):
c. atrial fibrillation
Due to (or as a consequence of):
d. Hypertension

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypoalbunaemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: D37588
29d. Date signed (Month, Day, Year): 1/31/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAFIK NASR . MD 135 W. Dares Beach Rd #109 Prince Frederick Md 20678

**State Registrar**

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

20

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04985

MARY ELIZABETH MYRICK

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Mary Elizabeth Myrick
2. Date of Death (Month, Day, Year): JANUARY 31, 2001
3. Time of Death: 11:00 P.M

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 219-20-4521
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Yeer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Oct. 16, 1927
9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1442 Buckhorn Rd.
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: own home

17. Feiher's Neme (First, Middle, Last): Clarence Hatfield
18. Mother's Name (First, Middle, Maiden Sumeme): Geneva Smith

19a. Intorment's Name/Relationship (Type, Print): Jack R. Myrick/ son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3307 Hooper Rd. New Windsor, MD 21776

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Locust Grove Cemetery
Date: 2/3/01
20c. Location - City or Town, Stete: nr. Mt. Airy, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler
22. Name and Address of Feciility: Hartzler Funeral Home, 310 Church St. New Windsor, MD 21776

**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart tailure. List only one ceuse on eech line.

Approximate interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): e. SEPSIS

Due to (or es a consequenca of):

Sequentially lisi conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but noi resulting in the underlying cause given in Part I.

a/ ATRIAL FIBRILLATION
/o PARKINSONS DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of injury - At home, ferm, street, tactory, office buiiding, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The lew requires thet tha death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: MD
29c. License number: D 51245
29d. Date signed (Month, Dey, Yeer): JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SAJID SHARIF CARROLL COUNTY GENERAL HOSPITAL. WESTMINSTER-MD 200 Memorial Avenue 21157

**State Registrar**

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04986

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Stuart Edgar Myers

2. Date of Death Month Day Year: February 3rd, 2001

3. Time of Death: 9:50 P.

4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

**Funeral Director**

5. Social Security Number: 103-12-0755

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 3, 1914

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Hampstead

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 18617 Falls Road

10f. Zip Code: 21074

10g. Citizen of What Country?: USA

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: WWII

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: fox hunter / harness maker

16b. Kind of Business/Industry: hunting

17. Fether's Neme *(First, Middle, Last)*: William H. Myers

18. Mother's Name *(First, Middle, Maiden Surname)*: Bessie Shock

19a. Informant's Neme/Reletionship *(Type, Print)*: Evelyn L. Myers (wife)

19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 18617 Falls Rd. Hampstead MD 21074

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other place)*: Crest Lawn Mem. Gardens

Dete: 2/7/01

20c. Location - City or Town, Stete: Marriottsville, MD

21. Signeture of Funeral Service Licensee: Brian L. Haight

22. Name end Address of Fecility: Haight Funeral Home & Ch, P.O. Box 195 Sykesville MD 21784

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Final diseese or condition resulting in deeth)

e. Acute Myocardiac Infarction

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lesf

b.

Due to (or es a consequenca of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: MD

29c. License number: D48006

29d. Date signed *(Month, Dey, Year)*: February 3rd, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): KOFI BOATEY, 200 memorial Ave, Westminster, MD 21157

**State Registrar**

31. Dete filed *(Month, Dey, Year)*: FEB 06 2001

32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

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Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

Stuart Myers

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04987

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Allen S. Milbourne JR.

2. Date of Death: Month 2 Day 1 Yaer 01

3. Time of Death: 10:25 pm

4a. Facility Name (If not institution, give street end number): McCready Health Services Foundation

4b. City, Town, or Location of Death: Crisfield

4c. County of Death: Somerset

**Funeral Director**

5. Social Security Number: 218-34-8159

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yeer): 11-08-38

9. Birthplace (State or Foraign Country): MD

Usual Rasidance of Decedant

10a. Stata: MD

10b. County: SOMERSET

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1☒Yas 2☐No

10e. Street and Number: 290 Somers Cove

10f. Zip Coda: 21817

10g. Citizan of What Country?: U.S.A

11. Maritel Status: 1☒Nevar Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Giva Yeer or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☒No Specify:

14. Rece - American Indian, Black, Whita, atc. Specify: Black

15. Decedant's Education (Specify only highast grade completed): Elamentary/Secondary (0-12): 11th; Collaga (1-4or 5+):

16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): LABORER

16b. Kind of Business/Industry: Seafood

17. Fether's Name (First, Middle, Last): Allen Milbourne Sr.

18. Mothar's Nama (First, Middle, Maidan Sumama): Annie Mae Brown

19a. Informant's Name/Relationship (Type, Print): Patricia Brown - Sister

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 10 Somers Cove Crisfield, MD 21817

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)

20b. Plece of Disposition (Nama of cemetary, cremetory or othar place): MT. Peer U.M.C Cemetery

Deta: 2-8-01

20c. Location - City or Town, Stata: Marion, MD

21. Signature of Funeral Service Licensee: A. E. Ward Jr.

22. Name end Address of Facility: Anthony E. Ward Funeral Home 314 Cove St. Crisfield, MD 21817

**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiana.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each lina.

Approximata Interval Batwean Onsat and Death

Immediate Cause (Final disaasa or condition resulting in daath) a. Cardio respiratory Arrest

Due to (or as a consequance of): Emphasitis

Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disaasa or injury that initiated events resulting in daath) Last

b. Due to (or as a consequance of): Auto Immune Deficiency Syndrome

c. Due to (or as a consequanca of):

d.

Part II. **Othar significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.: Cardiomyopathy.

23b. Did tobacco use contributa to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Were autopsy findings eveilable prior to compiation of cause of death? 1☐Yas 2☒No

25. Was casa rafarred to medical examiner? 1☐Yes 2☒No

26. Place of Daath (Check only ona): Hospital: 1☑Inpatiant 2☐ER/Outpatiant 3☐DOA Othar: 4☐Nursing Home 5☐Residance 6☐Othar (Specify)

27. Manner of Death: 1☑Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending invastigation 6☐Could not ba datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28e. Plece of Injury - At homa, farm, straet, factory, office building, atc. (Spacify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one) 1☐ **Certifying Phyaician:** To the bast of my knowladge, death occurred at tha time, data end place, and dua to tha causa(s) and manner as statad.
2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the time, date end place, and due to tha ceuse(s) and manner statad.

29b. Signatura and title of cartifiar: NCmil MD

29c. Licansa number: D00 D15715

29d. Data signad (Month, Day, Yaar): 2.2.01

30. Nama and addrass of parson who completed causa of daath (Item 23e) (Type, Print): 26423 BURTON AVE, CRISFIELD, MD. 21817 WILLIAM GILL M.D.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras thet tha daath certificata be executed within 24 hours after death.
To the Funeral Director: Aftar this certificate has been signed by the attending physician and completely filled in by tha funaral director, paga 2 should be detached for usa as tha burial-transit

**State Registrar**

31. Data filed (Month, Day, Yaar): FEB 07 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04988

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Sarah L. Meddaugh

2. Date of Death Month: February Day: 9, Year: 2001

3. Time of Death: 6:30 P.M.

4a. Facility Name (If not institution, give street and number): 3363 North Chatham Rd. Apt. B

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 219-01-4325

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 30, 1919

9. Birthplace (State or Foreign Country): Pennsylvania

**To Be Completed by Funeral Director**

Usual Residance of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Straat and Number: 3363 North Chatham Rd.

10f. Zip Coda: 21042

10g. Citizan of Whet Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Marriad 3☒ Widowad 4☐ Divorcad

12. Was Dacedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Raca - American Indian, Black, Whita, atc. Specify: white

15. Decedent's Education (Specify only highast grada completed): Elamantary/Secondary (0-12): 12; Collega (1-4or 5+):

16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired): Homemaker

16b. Kind of BusInass/Industry: Own Home

17. Fathar's Nama (First, Middle, Last): Ernest Campion

18. Mothar's Name (First, Middla, Maidan Surnama): Elsie (unknown)

19a. Informant's Name/Ralationship (Typa, Print): Joan Tranter / daughter

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 30 Foxmoor Ct. Owings Mills, MD. 21117

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of cematary, cramatory or othar placa): St. Johns Cemetery

Data: Feb. 13 2001

20c. Location - City or Town, Stete: Ellicott City, MD.

21. Signatura of Funeral Service Licansea: [signature] MO1096

22. Nama and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disaase, or complications thet causad tha deeth. Do not anter tha moda of dying, such es cardiac or respiretory errast, shock, or heert failura. List only ona causa on each lina.

Approximeta Intarval Between Onsat and Daath

Immedieta Causa (Final disaesa or condition rasulting in daath)

a. Terminal Lung Cancer — Due to (or as a consequanca of): — months

Sequantially list conditions, if eny, laading to immadiata cause. Entar Underlying Causa (Disaase or injury that initiated events rasulting in daath) Last

b. Dua to (or as e consaquanca of):

c. Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying causa givan in Pert I.

23b. **Did tobacco use contributa to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings evellebla prior to completion of causa of death? 1☐ Yas 2☒ No

25. Was case refarred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath (Check only ona)

Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA

Othar: 4☐ Nursing Homa 5☒ Residanca 6☐ Other (Spacify)

27. Mannar of Deeth: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)

28f. Location (Street and Numbar or Rural Routa Number, City or Town, State)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred et tha time, date end place, and dua to tha causa(s) and manner as stated.
2☐ **Medical Examinar:** On tha basis of examination and/or investigetion, in my opinion, daath occurred et tha time, date end place, and due to the causa(s) and mannar stated.

29b. Signatura and titla of certifiar: AM Canelas, MD

29c. Licansa number: D0055230

29d. Data signad (Month, Day, Year): Feb. 10, 2001

30. Nama and addrass of parson who complated causa of daath (Item 23e) (Type, Print): 1120 N Rolling Rd Catonsville MD. 21228 Ann Marie Canelas

**State Registrar**

31. Data filed (Month, Day, Year): FEB 12 2001

32. Registrar's Signature: Penelope D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** Tha law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es tha burial-transit

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State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04989

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Naomi M. Melewicz
2. Date of Death (Month, Day, Year): February 10, 2001
3. Time of Death: 10:30 am
4a. Facility Name (If not institution, give street and number): Holy Cross Rehab & Nursing Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

**Funeral Director**

5. Social Security Number: 065-14-6091
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 15 1921
9. Birthplace (State or Foreign Country): New York

**To Be Completed by Funeral Director**

Usuet Residence of Decedent

10a. State: Md.
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No XX
10e. Street end Number: 6703 McCahill Terrace
10f. Zip Code: 20707
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married XX Married 3☐ Widowed 4☐ Divorcad
12. Was Decadent Ever In U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ XX No Specify:
14. Raca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Stephen Pink
18. Mother's Name (First, Middle, Maiden Surname): Rose Juracka

19a. Informant's Name/Relationship (Type, Print): Frank Melewicz / spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6703 McCahill Terrace Laurel, Maryland 20707

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Neme of cametery, crematory or other place): San Francisco National Cem. Date: Feb. 21, 2001
20c. Location - City or Town, State: San Francisco, Ca.

21. Signature of Funeral Service Licensee: ▶ Gy S Ky /M00770
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Respiratory Failure
Due to (or es e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b. Pnuemonia
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.: CVA; Decubitus

23b. Did tobacco use contributa to the cauae of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown XX

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No XX
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No XX

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No XX
26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ XX Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): XX **Certifying Phyaician**: To the best of my knowledge, death occurred et the time, dete and piece, end due to the ceuse(s) end manner as steted. 2☐ **Medical Examiner**. On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D0056219
29d. Date signed (Month, Day, Year): 2/12/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 11906 Darnestown Road Suite G North Potomac, Maryland 20878

**State Registrar**

31. Date filed (Month, Day, Year): FEB 12 2001
32. Registrar's Signature: ▶ [signature] G. Sparks

**Baltimore, Maryland 21215-0020**

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician end completely filled in by the funerel director, page 2 should be detechad for use es the buriel-transit

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DHMH 16 Rev 6/95

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04990

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ALBERT HENRY NICKERSON
2. Date of Death (Month, Day, Year): February 3 2001
3. Time of Death: 0741
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 213-14-1115
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 22, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 406 Prince Street
10f. Zip Code: 21804
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): –
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Shipping Department
16b. Kind of Business/Industry: Manhattan Shirt Factor

17. Father's Name (First, Middle, Last): Homer Nickerson
18. Mother's Name (First, Middle, Maiden Surneme): Dora Vandalier

19a. Informant's Name/Relationship (Type, Print): Roxie B. Nickerson/Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 406 Prince St., Salisbury, MD 21804

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Wicomico Memorial Park
Date: 2/6/01
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: David A. Thompson M01051
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SUBDURAL HEMATOMA - Acute — 36 Hours
Due to (or as a consequence of):
b. FALL -
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
c. COUMADIN
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HEART VALVE REPLACEMENT
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☑ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☑ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): 1/31/01
28b. Time of Injury: 1100 a M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: transfering from bed to wheel chair
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): residence
28f. Location (Street and Number or Rural Route Number, City or Town, Stete): 406 Prince St. Salisbury MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.D. DME
29c. License number: HJ0497
29d. Dete signed (Month, Day, Year): 2/3/01

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): Chris Snyder 106 Milford St. Salisbury, Md. 21804

**State Registrar**

31. Dete filed (Month, Day, Year): FEB 06 2001
32. Registrer's Signeture: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Albert Nickerson 213-14-1115

5DA

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# *Certificate of Death*

Reg. No. 2001 04991

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Elsie M. Owens
2. Date of Death (Month, Day, Year): February 14 2001
3. Time of Death: 21:12
4e. Facility Name *(If not institution, give street and number)*: Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

**Funeral Director**

5. Social Security Number: 216-42-0004
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 26, 1909
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Elkridge
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5010 Landing Rd.
10f. Zip Code: 21075
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Thomas Taylor
18. Mother's Name *(First, Middle, Meiden Surneme)*: Elsa Katri Paakkonen

19a. Informant's Name/Relationship *(Type, Print)*: Eileen Lankford / daughter
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 607 Hollen Rd. Baltimore, Maryland 21212

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Placa of Disposition *(Neme of cemetery, cremetory or other pleca)*: Metro Crematory
Date: Feb. 16 2001
20c. Location - City or Town, State: Catonsville, Maryland

21. Signeture of Funeral Service Licensee: [signature] M01096
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

**Physician /Medical Examiner**

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Myocardial Infarction — 1 hour

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other elgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D34951
29d. Date signed *(Month, Dey, Yeer)*: 2-15-2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Edward P. Tkaczuk 405 Frederick Road Suite 100 Catonsville, MD 21228

**State Registrar**

31. Date filed *(Month, Day, Year)*: FEB 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

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**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04992

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): Joyce Short Tiburzi Pilat
2. Date of Death (Month, Day, Year): February 5, 2001
3. Time of Death: 0212Am
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 213-36-6243
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 14 1939
9. Birthplace (State or Foreign Country): Pa..

Usual Residence of Decedent

10a. State: Md
10b. County: Worcester
10c. City, Town or Location: Ocean Pines
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 28 Seafarer Lane
10f. Zip Code: 21811
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Btack, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done duning most of working life. DO NOT use retired): banker
16b. Kind of Business/Industry: finance

17. Father's Name (First, Middle, Last): Gatewood Jack Short
18. Mother's Name (First, Middle, Maiden Surname): Margaret Short

19a. Informant's Neme/Reietionship (Type, Print): Sharon Tiburzi Jockle (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Liberty Ridge Ct., Owings Mills, Md 21117

20a. Method of Disposition: 1☐ Buriat 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): All County Cremation | Date: 2-6-2001
20c. Location - City or Town, State: Sykesville, Md

21. Signature of Funeral Service Licensee: Paige Haight Herbert
22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md 21784

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple trauma — 8hrs.

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uea contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to compietion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicat examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): 2/4/2001
28b. Time of Injury: 1830 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: MVA
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): Rt. 13 Pocomoke
28f. Location (Street and Number or Rural Route Number, City or Town, State): Pocomoke MD

**Medical Certification: To Be Completed by Physician/Medical Examiner**

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) end menner es steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: DME
29c. License number: H50497
29d. Date signed (Month, Day, Year): 2/5/01
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Christopher Snyder, DME 104 Milford St. Suite 201 Salisbury, MD. 21801

**State Registrar**

31. Date filed (Month, Day, Year): FEB 07 2001
32. Registrer's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**To Be Completed by Funeral Director**

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Doyce Pilat

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate hes been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04993

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): THOMAS EDWARD PHILLIPS
2. Date of Death (Month, Day, Year): February 7, 2001
3. Time of Death: 9:20AM
4a. Facility Name (If not institution, give street and number): Charles County Nursing Rehab Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

**Funeral Director**

5. Social Security Number: 579-36-9214
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 14, 1930
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: La Plata
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 419 Linden Lane
10f. Zip Code: 20646
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plate Maker
16b. Kind of Business/Industry: Printing

17. Father's Name (First, Middle, Last): Oscar Aloysius Phillips
18. Mother's Name (First, Middle, Meiden Sumeme): Florence Capplan Phillips

19a. Informant's Name/Relationship (Type, Print): Anne Phillips/Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 419 Linden Lane, La Plata,MD 20646

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removel from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Brinsfield-Echols Crem
Date: 2/8/01
20c. Locetion - City or Town, State: Charlotte Hall,MD

21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Neme end Address of Facility: BRINSFIELD-ECHOLS FUNERAL HOME,P.A. P.O. BOX 128 CHARLOTTE HALL,MD. 20622

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Finai disease or condition resulting in death): a. PARKINSON'S DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D53885
29d. Dete signed (Month, Dey, Year): 2/7/2001

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): VENKAT. S. KAMANAN 6 POST OFFICE ROAD #101 WALDORF MD 20602

**State Registrar**

31. Date filed (Month, Day, Year): FEB 09 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020**

**To Be Completed by Funeral Director**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04994

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): GEORGE BRADLEY PADGETT, JR.

2. Date of Death: Month FEB, Day 04, Year 2001

3. Time of Death: 11:00 A

4a. Facility Name (If not institution, give street and number): Spa Creek Center Genesis Elder Care

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

**Funeral Director**

5. Social Security Number: 579-42-1945

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 10 1932

9. Birthplace (State or Foreign Country): Wash., D.C.

Usual Residence of Decedent

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: Dunkirk

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 675 Jewell Road

10f. Zip Code: 20754

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): George Bradley Padgett, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary Ellen Beach

19a. Informent's Name/Relationship (Type, Print): Ursula L. Padgett / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 112 Dunkirk, MD 20754

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Southern Memorial Gardens Date: 2/7/01

20c. Location - City or Town, State: Dunkirk, MD

21. Signature of Funeral Service Licansee: William R. Gow

22. Name and Address of Facility: Rausch Funeral Home, P.A. Owings, MD 20736

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting In death): a. metastatic cancer, unknown primary — IM

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or es a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uaa contributa to the cauae of deeth? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D32036

29d. Date signed (Month, Day, Year): 2/5/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary T. Sprague 2108 Ft. Donald Drive Chester, MD 21619

**State Registrar**

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: [signature] Spark

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**To be Completed by Funeral Director**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04995

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): ALYCE V. REMENTER

2. Date of Death (Month, Day, Year): January 31, 2001

3. Time of Death: 1155

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

**Funeral Director**

5. Social Security Number: 221-14-3162

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 22, 1917

9. Birthplace (State or Foreign Country): WILMINGTON, DE

Usual Residence of Decedent

10a. State: DELAWARE

10b. County: SUSSEX

10c. City, Town or Location: GEORGETOWN

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 23063 REMENTER ROAD

10f. Zip Code: 19947

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY

16b. Kind of Business/Industry: MILL

17. Father's Name (First, Middle, Last): RAYMOND ESHAM

18. Mother's Name (First, Middle, Maiden Surname): MARY ELIZABETH BEAUCHAMP

19a. Informant's Name/Relationship (Type, Print): RICHARD RAWLINS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT 2, BOX 208K, GEORGETOWN, DE 19947

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ASBURY CHURCH CEMETERY

Date: 02/05/01

20c. Location - City or Town, State: GEORGETOWN, DE

21. Signature of Funeral Service Licensee: M00866 S. Keith Rawlins

22. Name and Address of Facility: PARSELL FUNERAL HOMES - DODD-CAREY CHAPEL 307 NORTH BEDFORD ST. GEORGETOWN, DE 19947

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardiopulmonary arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. Severe Aortic Stenosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ramesh Agarwal, M.D.

29c. License number: 54807

29d. Date signed (Month, Day, Year): 1-31-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMESH AGARWAL, M.D. 1515 S. DIVISION ST. SALISBURY, MD 21804

**State Registrar**

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: G Sparks

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**Medical Certification: To Be Completed by Physician/Medical Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Baltimore, Maryland 21215-0036**

**Division of Vital Records, P.O. Box 68760,**

Alyce Rementer

14 MP

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04996

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: CHARLES EDWARD RIDGLEY, SR.

2. Date of Death (Month, Day, Year): FEBRUARY 4, 2001

3. Time of Death: 3:57 PM

4e. Facility Name *(If not institution, give street and number)*: CARROLL COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: WESTMINSTER

4c. County of Death: CARROLL

**Funeral Director**

5. Social Security Number: 212-18-9412

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 25, 1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 5837 White Rock Road

10f. Zip Code: 21784

10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: Cabinetry

17. Father's Neme *(First, Middle, Last)*: Herbert Fowler Ridgley

18. Mother's Name *(First, Middle, Maiden Surneme)*: Mary Theresa Amoss

19e. Informent's Neme/Relationship *(Type, Print)*: Clara L. Ridgley/wife

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 5837 White Rock Rd, Sykesville, MD 21784

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Lakeview Memorial Park

Dete: 2/7/01

20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: Suzanne Flaherty Myers

22. Name end Address of Fecility: Myers Funeral Home, 91 Willis Street, Westminster, MD 21157

**Physician /Medical Examiner**

23e. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Final disease or condition resulting in deeth): a. Adult Respiratory Distress Syndrome

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or Injury thet Initieted events resulting in death) Last

b. Bilateral pneumonia

Due to (or es a consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditione** contributing to deeth but not resulting in the underlying cause given in Part I.

COPD, Prim HTN, Colon Cancer

23b. Did tobacco use contribute to the cause of death? 1☒ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner steted.

29b. Signeture end titte of certifier: ▶ Mansuriya, MD

29c. License number: D 51705

29d. Date signed *(Month, Dey, Yeer)*: 2-5-01

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): M. PANSURIYA, 419F Malcolm Dr, Westminster, MD 21157

**State Registrar**

31. Dete filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signeture: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires thet the deeth certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ridgley, Charles SR

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 04997

**Physician /Medical Examiner**

1. Decedent's Name *(First, Middle, Last)*: Dr. Sherman S. Roddy

2. Deta of Death — Month: January Day: 23 Year: 2001

3. Tima of Death: 7:20 PM

4a Facility Nama *(If not institution, giva street and number)*: 3036 Hernwood Rd.

4b. City, Town, or Location of Death: Woodstock

4c. County of Death: Baltimore

**Funeral Director**

5. Social Sacurity Numbar: 360-22-4718

6. Sax: 1☒M 2☐F

7. Aga *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Yaar — Months: Days:

If Undar 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Year)*: Aug. 3, 1923

9. Birthplaca *(Stata or Foraign Country)*: Maine

Usual Rasidanca of Dacadant

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Woodstock

10d. Inside City Limits: 1☐Yas 2☒No

10e. Streat and Number: 3036 Hernwood Rd.

10f. Zip Coda: 21163

10g. Citizan of What Country?: United States

11. Marital Status: 1☐Navar Marriad 2☒Marriad 3☐Widowad 4☐Divorcad

12. Was Dacadant Ever in U.S. Armad Forcas? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:

13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☒No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Dacadant's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): Collaga (1-4or 5+): 5+

16a. Dacadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratirad)*: Clergy

16b. Kind of Business/Industry: Presbyterian

17. Father's Nama *(First, Middla, Last)*: Clarence S. Roddy

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Florence Matheson

19a. Informant's Name/Ratationship *(Type, Print)*: Rosalyn N. Roddy (Wife)

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 3036 Hernwood Rd. Woodstock, MD 21163

20a. Mathod of Disposition: 1☐Burial 2☒Cramation 3☐Ramovat from Stata 4☐Donation 5☐Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Carroll Cremation, Inc.

Data: Jan. 24, 2001

20c. Location - City or Town, State: Hampstead, MD

21. Signatura of Funaral Sarvica Licansaa: Todd A. Kellner

22. Nama and Addrass of Facility: Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784

**Physician /Medical Examiner**

23a. Part1. Entar tha disaasa, or complications that causad the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona ceusa on each line.

Approximata Intarval Batwaan Onsat and Death

Immadiata Causa (Finat disaasa or condition rasulting in daath)

a. Respiratory Insufficiency — 1 week

Dua to (or as a consaquanca of):

b. Malignent Mesothelioma — 2 years

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiatad avants rasulting in daath) Last

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.: asthma

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yas 2☐No

25. Was case rafarrad to medical examiner? 1☐Yas 2☒No

26. Placa of Death *(Check only ona)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Othar: 4☐Nursing Homa 5☒Rasidanca 6☐Othar *(Specify)*

27. Mannar of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledga, daath occurrad at tha time, data and placa, and dua to the cause(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of axaminetion and/or investigation, in my opinion, daath occurrad at the time, data and placa, and due to the cause(s) and manner stated.

29b. Signatura and Titla of cartifiar: A Zimrin MD

29c. Licansa number: D39639

29d. Data signad *(Month, Day, Year)*: 1-24-01

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): Ann Zimrin MD 2401 W. Belvedere Baltimore, Md 21210

**State Registrar**

31. Data filad *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

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**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

01-635-013
JOHN RILEY
JVW

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

# Certificate of Death

Reg. No. 2001 04998

**Physician /Medical Examiner**

| 1. Decedent's Name (First, Middle, Last) | 2. Date of Death Month Day Year | 3. Time of Death |
|---|---|---|
| John Michael Riley | FEBRUARY 05, 2001 | 11:43 A.M. |

| 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
|---|---|---|
| 6019 KENNARD COURT | ELDERSBURG | CARROLL |

**Funeral Director**

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 226-86-7658 | 1☒M 2☐F | 46 Yrs. | | | July 29, 1954 | Maryland |

**Usual Residence of Decedent**

| 10a. State | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| Maryland | Carroll | Eldersburg | 1☐Yes 2☒No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
|---|---|---|
| 6019 Kennard Ct. | 21784 | United States |

| 11. Marital Status | 12. Was Decedent Ever in U.S. Armed Forces? | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
|---|---|---|---|
| 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced | 1☐Yes 2☒No If Yes, Give Year or Dates: | 1☐Yes 2☒No Specify: | Specify: White |

| 15. Decedent's Education (Specify only highest grade completed) | | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4or 5+) | | |
| | 4 | Social Insurance Specialist | Social Security Admin. |

| 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) |
|---|---|
| John E. Riley | Lois Wilson |

| 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ines M. Riley (Wife) | 6019 Kennard Ct. Eldersburg, MD 21784 |

| 20a. Method of Disposition | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State |
|---|---|---|---|
| 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify) | Carroll Cremation | Feb. 9, 2001 | Hampstead, MD |

21. Signature of Funeral Service Licensee: Todd S. Keller

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784

**Physician /Medical Examiner**

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hanging

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No INSPECTION

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify) X SCENE

27. Manner of Death: 1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): 2/5/01

28b. Time of Injury: UNK M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: Subject hanged self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): AT HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 6019 Kennard Ct. 21784

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Locke M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): FEBRUARY 06, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

**State Registrar**

31. Date filed (Month, Day, Year): FEB 06 2001

32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

**Baltimore, Maryland 21215-0036**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To Be Completed by Funeral Director**

**Division of Vital Records, P.O. Box 68760,**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification; To Be Completed by Physician/Medical Examiner**

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

*Certificate of Death*

Reg. No. 2001 04999

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
**Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Physician /Medical Examiner**

**Funeral Director**

**To Be Completed by Funeral Director**

| 1. Decedent's Name (First, Middle, Last) | 2. Dete of Death Month / Dey / Yeer | 3. Time of Death |
|---|---|---|
| Maxine Elenor Rosenkrans | Jan. 31 2001 | 2225 |

| 4a Facility Name (If not institution, give street end number) | 4b. City, Town, or Location of Death | 4c. County of Deeth |
|---|---|---|
| Harford Memorial Hospital | Havre de Grace | Harford |

| 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthdey) | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min. | 8. Dete of Birth (Month, Dey, Yeer) | 9. Birthplace (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 178-16-4893 | 1☐ M 2☒ F | 81 Yrs. | | | 12/18/1919 | Pennsylvania |

Usual Residence of Decedent

| 10a. Stete | 10b. County | 10c. City, Town or Location | 10d. Inside City Limits |
|---|---|---|---|
| MD | Harford | Havre de Grace | 1☒ Yes 2☐ No |

| 10e. Street and Number | 10f. Zip Code | 10g. Citizen of Whet Country? |
|---|---|---|
| 505 Congress Ave., Apt.203 | 21078 | USA |

| 11. Meritet Stetus | 12. Wes Decedent Ever in U.S. Armed Forces? | 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indien, Black, White, etc. |
|---|---|---|---|
| 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced | 1☐ Yes 2☒ No If Yes, Give Yeer or Detes: | 1☐ Yes 2☒ No *Specify:* | *Specify:* White |

| 15. Decedent's Eduction (Specify only highest grade completed) | | 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
|---|---|---|---|
| Elementery/Secondery (0-12) | College (1-4or 5+) | | |
| 12th | | Homemaker | Home |

| 17. Father's Neme (First, Middle, Last) | 18. Mother's Neme (First, Middle, Maiden Surneme) |
|---|---|
| Unknown | Unknown |

| 19e. Informant's Name/Reletionship (Type, Print) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Edward Rosenkrans- Son | 1204 Bern Drive, Havre de Grace, MD 21078 |

| 20a. Method of Disposition | 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) | Dete | 20c. Location - City or Town, Stete |
|---|---|---|---|
| 1☒ Buriat 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify) | Harford Memorial Grdns. | 2/5/01 | Aberdeen, MD |

| 21. Signeture of Funeral Service Licensee | 22. Neme end Address of Feciility |
|---|---|
| ▶ Elaine M. Smith | Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 |

**Physician /Medical Examiner**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)
a. UroSepsis
Due to (or as e consequence of):
b. Renal Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last
Due to (or es e consequence of):
c. Cerebrovascular Accident
Due to (or es e consequence of):
d. Dehydration

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Parkinsons Disease
Depression
HTN

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

| 24a. Wes en autopsy performed? | 24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? |
|---|---|
| 1☐ Yes 2☑ No | 1☐ Yes 2☐ No |

| 25. Wes cese referred to medicel examiner? | 26. Place of Death (Check only one) | |
|---|---|---|
| 1☐ Yes 2☑ No | Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) |

| 27. Manner of Death | 28a. Dete of Injury (Month, Dey Yeer) | 28b. Time of Injury | 28c. Injury et Work? | 28d. Describe how injury occurred |
|---|---|---|---|---|
| 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined | | M | 1☐ Yes 2☐ No | |

| 28e. Piece of Injury - At home, farm, street, foctory, office building, etc. (Specify) | 28f. Location (Street and Number or Rurel Route Number, City or Town, State) |
|---|---|
| | |

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and ptace, and due to the cause(s) end manner steted.

| 29b. Signeture and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
|---|---|---|
| ▶ Hi Sup Sim | D4641 2 | 2/1/01 |

30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print)
Hi Sup Sim 319 S. Union Ave Hbg MD 21078

**State Registrar**

| 31. Dete filed (Month, Day, Yeer) | 32. Registrar's Signeture |
|---|---|
| FEB 5 2001 | B. Sparks |

DHMH 16 Rev 6/95

ORIGINAL

Rosmkras, Maxine E 2nd
1-31-01
Time of dict 2025 -
10

**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

# Certificate of Death

Reg. No. 2001 05000

**Physician /Medical Examiner**

1. Decedent's Name (First, Middle, Last): DILLON KYLE RAY
2. Date of Death (Month, Day, Year): FEB 2, 2001
3. Time of Death: 12:38 pm
4a. Facility Name (If not institution, give street end number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

**Funeral Director**

5. Social Security Number: 218-34-1534
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1/15/1938
9. Birthplace (State or Foreign Country): Sparta, NC

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Whiteford
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1824 Ridge Road
10f. Zip Code: 21160
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Welder
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Joseph Ray
18. Mother's Name (First, Middle, Maiden Surname): Zenna Brown

19a. Informant's Name/Relationship (Type, Print): Evelyn J. Ray/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1824 Ridge Road, Whiteford, MD 21160

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Mem. Gardens
Date: 2/5/01
20c. Location - City or Town, State: Bel Air, MD

21. Signature of Funeral Service Licensee: Jeffrey P. Lovelidge
22. Name and Address of Facility: Harkins Funeral Home, Inc., Delta, PA

**Physician /Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer with brain metastasis

Due to (or as a consequence of):
b. Congestive Heart Failure

Due to (or as a consequence of):
c. Diabetes Mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
d. Coronary artery disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Lee MD
29c. License number: D20661
29d. Date signed (Month, Day, Year): 2/6/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Lee MD - 69 Revolutions St., Havre de Grace MD 21078

**State Registrar**

31. Date filed (Month, Day, Year): FEB 5 2001
32. Registrar's Signature: D. Spach

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ORIGINAL

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**To Be Completed by Funeral Director**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Ray, Dillon 1238 2/2/01 PR Lee MD

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